Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52473921M
Compliance #: H52473932C

Date Concluded: August 19, 2024

Name, Address, and County of Licensee Investigated:
Kittson Healthcare Center
1010 South Birch Ave.
Hallock, MN 56728
Kittson County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused a resident when the AP roughly grabbed the resident by the arm to transfer the resident, then restrained the resident by putting her in a recliner chair against her will and took the resident's wheelchair away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Video surveillance showed the AP did not grab the resident by the arm or force her to sit in the recliner. The recliner footrest was observed down, and the resident appeared calm, content, with no signs of distress while in the recliner.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), facility internal investigation,

personnel files, staff schedules, previous federal investigation documentation, and related facility policy and procedures.

The resident resided in a nursing home with diagnoses including Alzheimer's Disease, Dementia without behavioral disturbance, mood disturbance, anxiety, and psychotic disturbances.

The resident's assessment and care plan indicated the resident was cognitively impaired but able to make her needs known, was usually understood, had clear speech, and wandered frequently. The assessment and care plan indicated the resident was a limited assist from one staff with transfers and the resident was highly involved in the transfer. The care plan indicated the resident required repositioning every 3 hours.

A federal investigation indicated when interviewed the nurse working the evening of the incident reported the AP restrained the resident by putting her in the recliner chair to keep the resident from wandering. The nurse stated the resident was able to transfer herself, but the AP grabbed the resident by the armpits to transfer her.

The resident's progress notes indicated the resident frequently wandered the facility, was redirectable, and sat in the recliner in the common area. The nurse's progress note from the night of the incident indicated the resident had no concerns noted.

A facility investigation indicated the nurse failed to report the concern of the AP restraining the resident. The investigation indicated facility video surveillance was reviewed which showed the resident was transferred safely by the AP into a recliner chair in the common area with multiple staff, residents, and visitors around. The video showed the footrest of the recliner was down, the resident appeared calm, content, and showed no distress or agitation with being in the recliner. The facility investigation indicated staff interviewed at the time of the incident witnessed the nurse use vulgar language toward the AP and the nurse told the AP she did not want the resident in the recliner. The staff interview indicated the AP transferred the resident back into her wheelchair because the nurse instructed her to do so.

A review of the video surveillance recording showed the AP wheeling the resident to the common area while holding the hand of another resident. Although the AP transferred the resident without a transfer belt, it did not appear to cause the resident discomfort. The recliner footrest was observed down. The resident appeared calm, content, and without distress or agitation during interactions with the AP or while in the recliner. The nurse was not observed to intervene during the interaction with the resident and the AP. Multiple staff, residents, and visitors were observed in the area at the time of the incident, and none appeared to be alerted to any concerns with the resident.

A review of internal leadership email correspondence indicated the nurse had received coaching regarding conduct concerns with the AP and multiple other staff in the facility. The

email indicated the facility planned to terminate the nurse's employment for lack of improvement the day before the nurse reported the concern.

When interviewed one staff witness stated the nurse targeted the AP and the day of the incident used vulgar language calling the AP a "stupid bitch" for putting the resident in the recliner. The witness stated the nurse told the AP she "did not want the resident in the recliner. " The staff stated the resident routinely sat in the recliner after meals, was able to verbalize if she did not want to go in the recliner, and the resident never expressed she did not want to be in the recliner the night of the incident. The staff stated she observed the resident calmly seated in the recliner, with no agitation or distress noted.

When interviewed the AP denied roughly handling or restraining the resident to the recliner to prevent her from wandering. The AP stated it was the resident's usual routine to sit in the recliner after supper. The AP stated the resident pushed her wheelchair away trying to look outside the patio door, so she moved the wheelchair out of her way. The AP stated the recliner footrest was down and the resident was calm and content being in the recliner. The AP indicated she heard the nurse say, "that bitch put the resident in the recliner," and asked another staff to transfer the resident back into her wheelchair. The AP stated she transferred the resident back into her wheelchair because that was what the nurse wanted.

When interviewed facility leadership stated the AP had no history of abusive conduct concerns working with residents at the facility. Leadership stated the incident was investigated with no concern of abuse or restraint identified. Leadership stated the AP and multiple other staff had reported harassment concerns with the nurses conduct just prior to the incident. Leadership staff stated the report about the AP was made by the nurse in a retaliatory way.

When interviewed the resident's family member stated she had observed the resident utilize the recliner on multiple occasions. The family member indicated she had no concerns the resident was restrained when she used the recliner and had no concerns with abusive conduct with staff.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: No, not interviewable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
When the facility became aware of the concern, they reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), investigated the incident, and reinforced education and training for staff.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON HEALTHCARE	1010 SOUTH BIRCH HALLOCK, MN 56728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52473921M/H52473932C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	