Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52581922M

Date Concluded: October 3, 2022

Name, Address, and County of Licensee Investigated:
Franciscan Health Center
3910 Minnesota Ave.
Duluth, MN 55802
St. Louis County

Facility Type: Nursing Home

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

Finding: Substantiated, individual responsibility

Nature of Visit:
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 resident was abused when the alleged perpetrators, AP-A and AP-B, (facility staff) restrained the resident and attempted to force the residents' dentures in her mouth as the resident screamed out in pain and asked them to stop.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. AP-A and AP-B were responsible for the maltreatment. Multiple witnesses heard the resident screaming and observed AP-A forcefully pinning the resident's hands and arms down to her wheelchair, while

AP-B held the back of the resident's head and aggressively attempted to shove dentures into the resident's mouth for several minutes. The resident was observed physically struggling to get away from AP-A and AP-B's restraint by thrashing and kicking at them.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's family member. The investigation included review of resident records including care plan, progress notes, incident reports, medication administration records, assessments, facility policy and procedures, facility investigation documentation, staff schedules, and the alleged perpetrator(s) personnel files.

The resident resided in a skilled nursing facility with diagnoses including dementia and anxiety disorder. The resident's assessment indicated the resident had severe cognitive impairment and had no behaviors. The resident required extensive assistance from one staff with activities of daily living including dressing and toileting; and partial to moderate assistance with oral hygiene including cleaning and inserting dentures.

The resident's care plan indicated the resident required assistance with grooming and personal hygiene. The resident received antianxiety medication less than five times with behavioral episodes in a month. The care plan indicated the resident was able to express her needs, and instructed staff to provide reassurance and encouragement to communicate. The care plan indicated staff were to encourage the resident to complete oral care step by step.

The residents progress notes from the day of the incident indicated AP-A documented the resident refused her medications at 4:00 p.m. and in the evening. At 5:00 p.m. AP-A documented the resident refused to put in her lower dentures for dinner.

The resident's medication administration records (MAR) on the day of the incident indicated the residents 4:00 p.m. orders included Methadone HCL 5 milligrams (mg) oral tablet with instructions to administer 5 mg one time per day for chronic pain. The MAR indicated AP-A had documented administering the medication as ordered, despite documenting a progress note the resident had refused the medication. The MAR also indicated the resident was prescribed Lorazepam (antianxiety medication) oral tab 0.5 mg, as needed every six hours for resisting cares, and presenting a risk to herself and staff during cares. The medication was not administered for resistance of cares on the day of the incident.

A review of the resident's signed physician orders at the time of the incident did not include use of restraints.

The facility investigation following the incident included interviews and handwritten statements indicating multiple staff had witnessed AP-A and AP-B standing over the resident while she sat in her wheelchair. AP-A was seen forcefully pinning the resident's hands/arms from movement to the arms of the wheelchair while AP-B held the back of the resident's head with one hand

and with her other hand attempted to force the resident's dentures into her mouth. The facility investigation indicated staff heard the resident yelling, "No, no, no," Stop, you're hurting me!" The residents shrill wailing screams were heard for several minutes as the AP's continued to restrain and force the dentures into the residents' mouth. Eventually AP-A and AP-B gave up trying to force the residents' dentures in and brought the resident to the dining room.

The facility investigation indicated when interviewed the day after the incident AP-A denied any wrongdoing, did not recall hearing the resident screaming, and indicated the resident turned her head away with attempt to place the resident's dentures in her mouth so they stopped and brought the resident to the table.

The facility investigation indicated when interviewed AP-B stated AP-A held the resident's hands because the resident was combative and resistive with all cares and grabbed and hit at them.

When interviewed by the investigator several staff members reported hearing the resident shrill, wailing screams during the incident. Staff reported it sounded like the resident had fallen, was injured, or was being hurt, and indicated it was not the resident's normal verbal response to resistance of care. Staff stated the residents' screams were heard in other resident rooms, and from another floor. Staff stated when they looked to see what was going on two staff, AP-A, and AP-B, were observed standing over the resident. AP-B was forcefully pinning the resident's hands and arms down to restrain her from movement. The resident was observed struggling to get away from AP-A by thrashing her body and kicking at staff. Staff stated while AP-A restrained the resident AP-B held one hand on the back of the resident's head and attempted to force dentures into her mouth with the other hand, as the resident repeatedly turned her head away. Staff stated the resident yelled "No, no, no, STOP, you're hurting me!" Despite the resident's refusal, AP-A and AP-B continued to restrain and attempt to put the dentures into the resident's mouth for several minutes while she cried out in pain. Staff stated after AP-A and AP-B gave up trying to put in the resident's dentures they brought her to the dining room table. Staff stated the resident appeared visibly shook up, afraid, and was breathing heavily.

When interviewed AP-A stated the resident was seated in her wheelchair while they [AP-A and AP-B] stood over the resident. AP-A stated she loosely held the resident's hands and arms from movement while AP-B attempted to put dentures into the resident's mouth. AP-A stated she held the resident's hands because she was flailing around while telling them not to put her dentures in. AP-A stated the resident repeatedly turned her head away while AP-B attempted to put her dentures in her mouth and was crying out and making noises, but they did not stop immediately because it was important for the resident to wear her dentures. AP-A stated after attempting for a few minutes they stopped trying to get the residents dentures in.

AP-B did not respond to multiple requests for interview.

In conclusion, abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: AP-A Yes, AP-B Refused to respond.

Action taken by facility:

Facility staff reported concerns of abuse, the facility suspended the staff involved and completed an investigation of the incident and provided staff education. AP-A and AP-B are no longer employed at the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance for the resident's right to be free from maltreatment. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.
You may also call 651-201-4890 to receive a copy via mail or email
The responsible parties will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Louise County Attorney
Duluth Attorney
Duluth Police Department
Department of Human Services
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00865	A. BUILDING: _____ B. WING _____	C 09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH CENTER	3910 MINNESOTA AVENUE DULUTH, MN 55802

(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 H52581922M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for H52581922M, tag identification 1850.	2 000		

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2 000	Continued From page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 1 resident (R1) reviewed was free from maltreatment. R1 was abused. Findings include: On August 31, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that two individual staff person(s) were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	