Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53162002M
Compliance #: H53169125C

Date Concluded: May 3, 2024

Name, Address, and County of Licensee Investigated:
New Richland Care Center
312 1st Street NE
New Richland, MN 56072
Waseca County

Facility Type: Nursing Home

Evaluator's Name: Brooke Anderson, 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.

Initial Investigation Allegation(s):
A facility staff/alleged perpetrator (AP) abused the resident when the AP yelled at the resident saying, "Why are you yelling instead of using your call light, can't you use your arm?" and "You could help a little bit, I know that you can."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the alleged perpetrator's (AP) actions of yelling at the resident were disrespectful and unprofessional, there was not a preponderance of evidence the actions of the AP did not meet the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), the facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policies and procedures, and the previous related federal survey.

The resident resided in a nursing home. The resident's diagnoses included Parkinson's disease and Lewy Body's dementia. The resident's care plan included assistance with dressing and grooming. The resident's assessment indicated the resident was cognitively intact.

The facility internal investigation indicated the resident was crying when facility staff #1 administered the resident's medications. The resident reported that he was crying because a staff member/alleged perpetrator (AP) yelled at him and said, "Instead of using your call light, can't you use your arm?" and "You could help a little bit, I know you can use your arm." After the incident the AP was no longer employed at the facility. The facility investigation indicated the resident returned to his baseline condition after the incident.

During an interview with the federal surveyor, facility staff #1 stated she heard the AP yelling at the resident from the nurse's station while the resident's door was closed. She did not intervene because she was in the middle of something.

During an interview with the federal surveyor, facility staff #2 stated she heard the AP yelling at the resident and when she went to open the resident's door, she didn't hear yelling anymore, so she didn't go in the resident's room.

During an interview, the AP stated the morning was busy and the resident was yelling from his room. The AP stated that she walked into the resident's room and asked, "Why are we yelling?" The resident responded with "Huh?", so she spoke louder. The AP denied yelling at the resident out of anger or malice but admitted to raising her voice because the resident couldn't hear her.

During an interview, the resident stated that the incident wasn't serious, and he had no concerns with the care provided at the facility.

During an interview with the federal surveyor, the resident's family member stated she was upset that the incident occurred but stated the resident wanted to continue living at the facility.

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;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed at the facility. The facility completed follow up assessments on the resident and the resident returned to his baseline status.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility noncompliance. 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.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00748	A. BUILDING: _____ B. WING _____	C 04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW RICHLAND CARE CENTER	312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072

(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 #H53162003M and H53162002M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction	2 000		

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2 000	Continued From page 1 (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		