

### Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name:			<b>Report Number:</b>	Date of Visit:		
Divine Providence Health Center			H5327004	February 8, 2017		
Facility Address:			<b>Time of Visit:</b>	Date Concluded:		
312 East George Street			8:30 a.m. to 2:30 p.m.	June 28, 2017		
<b>Facility City:</b> Ivanhoe			Investigator's Name and Pam Hovdet, RN, Special			
<b>State:</b> Minnesota	<b>ZIP:</b> 56142	County: Lincoln				

Nursing Home

### Allegation(s):

It is alleged that a resident was physically abused by a staff, alleged perpetrator (AP) when the AP slapped the resident's hand causing a large skin tear.

- **x** Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- **X** State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- **X** State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- **X** State Statutes Chapters 144 and 144A

# **Conclusion:**

Based on a preponderance of evidence, abuse occurred when the alleged perpetrator (AP) slapped the resident's hand and the resident sustained a skin tear.

The resident was diagnosed with dementia and severe cognitive impairment. The resident required assistance with all activities of daily living.

One afternoon, the resident was found standing up attempting to get his/her coat out of the closet. A staff member was unsuccessful with convincing the resident to sit back down in the wheelchair, so s/he called on the radio for assistance.

The AP entered the resident's room to assist with the resident. The initial staff member was standing behind the resident trying to get the resident to turn and sit down in the wheelchair. The AP stood to the left of the resident, and also attempted to convince the resident to sit down. The resident refused to sit down and grabbed the AP's left forearm with his/her right hand. The AP slapped the top of the resident's right hand. The contact from the hit made a very loud sound and the resident exclaimed, "Ow! That hurt." The AP replied, "You don't grab people." The AP left the resident's room and reported the hit to the nurse. The staff member noticed blood running from the skin tear on top of the resident's hand, down to the resident's palm. The staff member brought the resident to the nurse, who assessed the resident's hand and noted the resident sustained a 3.6 centimeter (cm) skin tear on top of the right hand where the AP hit the resident. The skin was peeled back and the wound was bleeding. The nurse cleaned and applied a dressing

to the wound.

During an interview, the resident stated the AP slapped the resident's right hand hard enough to cause a 1 1/2 inch skin tear on the top of the hand. Three weeks after the incident, a scar remained on the resident's right hand.

The staff member who was in the room stated the AP's open right hand came down hard and forcefully hit the resident's top right hand causing the skin tear.

When interviewed, the AP stated the resident grabbed the AP's left forearm. The AP's initial thought was to get the resident's hand off the AP's forearm. The AP reacted and slapped the top of the resident's hand causing the skin tear.

When interviewed by the investigator, the nurse stated the AP informed the nurse s/he had just hit the resident. The AP further explained the resident grabbed the AP's arm, and the AP hit the resident's hand and it was bleeding.

During a police investigation, the AP admitted slapping the resident. The officer forwarded his report to the county attorney for a charging decision.

Immediately after the incident, the director of nursing and a social service designee met with the AP, reviewed the facility policy on abuse, and escorted the AP out of the facility. The AP was terminated from employment at the facility.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

🛛 Abuse

☐ Neglect ☐ Not Substantiated Financial Exploitation

Inconclusive based on the following information:

### **Mitigating Factors:**

Substantiated

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and in	: was
determined that the 🖂 Individual(s) and/or 🔲 Facility is responsible for the	

Abuse Deglect Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place to prevent and report abuse. The AP's was trained on facility policy and procedure including vulnerable adult training. Staffing levels were reviewed for the day and shift the abuse occurred and the staffing level was comparable to other days.

The responsible party 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.

# Compliance:

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: X Yes 🗌 No

(The 2567 will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: 🗌 Yes 🗌 No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: X Yes No

(State licensing orders will be available on the MDH website.)

**Compliance Notes:** 

**Facility Corrective Action:** The facility took the following corrective action(s):

# **Definitions:**

# Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(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

### Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

# The Investigation included the following:

**Document Review:** The following records were reviewed during the investigation:

- **X** Medical Records
- **X** Medication Administration Records
- X Nurses Notes
- **x** Assessments
- **x** Physician Orders
- **x** Treatment Sheets
- **X** Physician Progress Notes
- **x** Care Plan Records
- **X** Social Service Notes
- **x** Skin Assessments
- **x** Facility Incident Reports
- **X** Laboratory and X-ray Reports
- X ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

Additional facility records:									
Resident/Family Council Minutes									
x Staff Time Sheets, Schedules, etc.									
Image: Second process of the second process of th									
Image: A construction of the									
Facility In-service Records									
x     Facility Policies and Procedures									
— .									
Number of additional resident(s) reviewed: Four									
Were residents selected based on the allegation(s)? $\odot$ Yes $\bigcirc$ No $\bigcirc$ N/A									
Specify:									
Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?									
● Yes ○ No ○ N/A									
Specify:									
<b>Interviews:</b> The following interviews were conducted during the investigation: Interview with complainant(s)									
Specify: If unable to contact complainant, attempts were made on:									
Specify:									
Specify:   If unable to contact complainant, attempts were made on:   Date: Time:   Date: Date:   Time:   Interview with family:       Yes     No     NA     Specify:									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Date:   Time:   Date:   Time:   Date:   Time:   Date:   Time:   Date:   Date:   Time:   Date:   Date:   Date:   Date:   Time:   Date:									
Specify:									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Date:   Did you interview the residents?   Itel yes   No									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Did you interview the resident(s) identified in allegation:   (a) Yes   (b) N/A   Specify:   Did you interview additional residents?   (a) Yes   (b) No   Total number of resident interviews: Nine									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Did you interview the resident(s) identified in allegation:   O No   NA   Specify:   Did you interview additional residents?   O No   Total number of resident interviews: Nine									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Date:   Tennessen Warnings									
Specify:									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Date:   Tennessen Warning given as required:    Yes   No   Total number of staff interviews:   Light									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Date:   Tennessen Warning given as required:    Yes   No      No No No No No No No No Total number of staff interviews: Eight Physician Interviewed:  Yes No No									
Specify:   If unable to contact complainant, attempts were made on:   Date:   Time:   Date:   Tennessen Warning   Total number of staff interviews:   Eight									

Facility Name: Divine Providence Health Report Number: H5327004 Center  $\bigcirc$  N/A Specify: Interview with Alleged Perpetrator(s): • Yes  $\bigcirc$  No Attempts to contact: Date: Time: Date: Time: Date: Time: If unable to contact was subpoena issued: O Yes, date subpoena was issued O No Were contacts made with any of the following: Emergency Personnel 🗵 Police Officers 🗌 Medical Examiner 🗌 Other: Specify **Observations were conducted related to: x** Personal Care **X** Nursing Services **x** Call Light **x** Dignity/Privacy Issues **x** Safety Issues **x** Facility Tour • N/A Was any involved equipment inspected: () Yes () No • N/A Was equipment being operated in safe manner: O Yes  $\bigcirc$  No Specify: By law enforcement of the wound Were photographs taken: • Yes  $\bigcirc$  No cc: **Health Regulation Division - Licensing & Certification** Minnesota Board of Examiners for Nursing Home Administrators The Office of Ombudsman for Long-Term Care **Ivanhoe Police Department** 

Lincoln County Attorney Ivanhoe City Attorney

		AND HUMAN SERVICES				FORM	: 11/03/2017 APPROVED 0938-0391
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C	
		245327	B. WING		06/02/2017		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		·
DIVINE F	ROVIDENCE HEALTH	H CENTER			312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 0	000	}		
	6/2/17 to follow up of complaint H532700 Center is in complia subpart B, requirem Facilities. The facility is enroll signature is not req page of the CMS-28 correction is require	a revisit was conducted on on deficiencies issued relate to 04 Divine Providence Health ance with 42 CFR Part 483, nents for Long Term Care ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 11/03/2017 FORM APPROVED

Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00339	B. WING		R-C <b>06/02/2017</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u></u>	
DIVINE F	PROVIDENCE HEALTI	H CENTER 312 EAST		T PO BOX 136		
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{2 000}	Initial Comments		{2 000}			
	*****ATTE	NTION******				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surver found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wh	nether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was		,		
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	follow up on correct complaint H532700	TS: Ilow-up was completed to tion orders issued related to 4. Divine Providence Health n compliance with state				
	The facility is enroll	ed in ePOC and therefore a				
Minnesota De ABORATORY	epartment of Health / DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6)	DATE

PRINTED: 11/03/2017 FORM APPROVED

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{2 000}	page of the CMS-2 correction is require	ige 1 uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents	: /				
Minnesota De STATE FORM	epartment of Health		6899	UYSK12	If continue	ion sheet 2 of 2	

# DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically delivered** 

November 9, 2017

Ms. Mary Swanson, Administrator Divine Providence Health Center 312 East George Street PO Box 136 Ivanhoe, MN 56142

Re: Complaint Number H5327004

Dear Ms. Swanson:

On June 2, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on April 18, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED C
		245327	B. WING	ì			0 18/2017
NAME OF F	PROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	•	í
DIVINE P	ROVIDENCE HEALTI	H CENTER			312 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		
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F 000	INITIAL COMMEN	rs	F	000			
F 223 SS=G	to investigate case following deficiency enrolled in ePOC a required at the bott CMS-2567 form. E POC will be used a		F:	223			
	neglect, misapprop and exploitation as includes but is not corporal punishme	ne right to be free from abuse, riation of resident property, defined in this subpart. This limited to freedom from nt, involuntary seclusion and emical restraint not required to symptoms.					
	abuse, corporal pu seclusion; This REQUIREME by: Based on interview facility failed to ens reviewed (R1) was	al, mental, sexual, or physical nishment, or involuntary NT is not met as evidenced v and document review, the ure one of five residents free from abuse when a					
	hand causing a ski Findings include:	lapped the resident on his right n tear.					
	admission record in	d was reviewed and the dentified diagnoses of on's disease and generalized					
		DER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/18/2017

		AND HUMAN SERVICES				FORM	: 04/18/2017 APPROVED . 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245327	B. WING	ì			(18/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	ROVIDENCE HEALTI	H CENTER			312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	COMPLETION DATE
F 223	Continued From pa	ige 1	F	223	3		
	11/7/16, indicated F assistance with act The Brief Interview score dated 11/7/16 cognitive impairment R1's nursing progre- indicated nursing as registered nurse (R hand when R1 grad later, NA-D brought bleeding skin tear of slap. RN-D and the cleaned the 3.6 cer and applied 5 steri An interview with N at 10:15 a.m. and e assistance with get wheelchair. NA-F e and while attempting grabbed NA-F's left NA-E stated NA-F t and forcefully slapp making a loud nois NA-F replied aggre people" and then le get R1 settled in the top of R1's right hat was peeled back. I desk to report the in assess the skin tea to report NA-F's tre	ess note dated 1/18/17, ssistant (NA)-F reported to N)-D he/she slapped R1's obed NA-F's arm. Seconds t R1 to RN-D to assess a on R1's right hand from NA-F's e director of nursing (DON) ntimeter (cm) long skin tear strips. A-E was conducted on 2/8/17, established NA-E requested ting R1 to sit down in his/her entered R1's room to assist og to get R1 to sit down, R1 t forearm with the right hand, took his/her open right hand, e. "R1 said "ow that hurts." sively to R1, "you don't grab off the room. NA-E was able to e wheelchair and noticed the nd was bleeding and the skin NA-E took R1 to the nurses ncident and have RN-D ar. NA-E then went to the DON atment towards R1.					
		ted on 2/8/17, at 1:20 p.m. e DON and SSD reviewed the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00339

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES				FORM	04/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245327	B. WING			18/2017	
NAME OF I	PROVIDER OR SUPPLIER	<b>I</b>			TREET ADDRESS, CITY, STATE, ZIP CODE		
DIVINE F	ROVIDENCE HEALTH	H CENTER		-	12 EAST GEORGE ST PO BOX 136 /ANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	facility's Vulnerable NA-F, prior to suspo of the facility that sa An interview with th conducted on 2/8/1 administrator stated on the Vulnerable A indicates Divine Pro abuse of any reside the police, physicial incident. An interview with R 2:15 p.m. R1 state and caused a 1 1/2 NA-F's fingernail we An interview with R 2/10/17, at 12:55 p. brought R1 to the n attention for a bleed right hand. RN-D u bleeding and clean cm long. RN-D and strips to close the sa An interview with th 3/1/17, at 10:25 a.n admitted to slappin frustration. The DC completed an invest on 1/18/17 . An interview with N at 10:50 a.m. NA-F to sit down in the w left forearm with his	Adult Policy immediately with ending and escorting NA-F out ame day. ee administrator was 7, at 1:45 p.m. The d staff receive annual training adult Policy, and the policy ovidence will not condone ent. The administrator notified n and R1's family of the 1 was conducted on 2/8/17, at d that NA-F slapped his hand inch tear on his hand when ent under his skin. N-D was conducted on .m. RN-D stated NA-E nurses desk for medical ding wound on the top of his used gauze to stop the the skin tear measuring 3.6 d the DON applied five steri skin tear. he DON was conducted on n. The DON stated NA-F g R1 on the right hand due to DN notified the administrator, stigation, and terminated NA-F	F 2	223			
FORM CMS-2	top of H1's right ha	nd with an open right hand and Obsolete Event ID: UYSK1	1	Fa	cility ID: 00339 If continu	ation she	et Page 3 of 4

		AND HUMAN SERVICES				FORM	04/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		- (X3) DATE SUR COMPLETE C	
		245327	B. WING			) 18/2017	
NAME OF F	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DIVINE P	ROVIDENCE HEALT	HCENTER			312 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 223	go of the forearm. wrong and reported A document titled, " to attend training se indicated NA-F atte training. A Divine F Employee Certificat by NA-F when hired had been provided Divine Providence I Compliance Code of purpose of the Corp An Employee/Supe 1/19/17, indicated of facility policy in rega Resident's rights ar was terminated effe The "Divine Provide Adult Abuse Preven 11/2016, defined at an accident or thera or could reasonably physical pain or inju- including but not lim	lent's hand off to get R1 to let NA-F acknowledged this was it to the DON. Imandatory for all departments ession" dated 7/19/16, anded Vulnerable Adult review Providence Health Center tion of Compliance was signed d on 3/18/14 indicated NA-F with education regarding Health Center's Corporate of Conduct and understood the porate Compliance Program. ervisor Conference letter dated on 1/18/17, NA-F violated and to Vulnerable Adults and nd due to the violation NA-F ective 1/18/17. ence Health Center Vulnerable nouse as conduct which is not apeutic conduct with produces y be expected to produce ury or emotional distress, nited to, the following: cking pinching, biting or	F	223			
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: UYSK1	1	Fa	acility ID: 00339 If cont	tinuation she	et Page 4 of 4

<u>Minnesc</u>	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00220	B. WING		C 04/18/20	
		00339			<u> </u>	0/2011
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE T PO BOX 136		
		H CENTER	MN 56142			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION******				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance re-inspection with a result in the assess that was violated do corrected. You may request a that may result from orders provided that the Department with notice of assessment INITIAL COMMENT A complaint investi investigate compla	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.				
	of State licensure of	cipate in the electronic receipt orders consistent with the nent of Health Informational ilable at				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

UYSK11

(X6) DATE

ta Department of He	alth		· · · · · · · · · · · · · · · · · · ·		
IT OF DEFICIENCIES				(X3) DATE S COMPL	
	00339	B. WING		C 04/18	B/2017
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PROVIDENCE HEALT	H CENTER		Г РО ВОХ 136		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
http://www.health.s obul.htm The Stat delineated on the a Department of Hea electronically. Alth necessary for State the word "corrected Then indicate in the process, under the date your orders w electronically subm	tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota lth orders being submitted ough no plan of correction is e Statutes/Rules, please enter I" in the box available for text. e electronic State licensure heading completion date, the II be corrected prior to itting to the Minnesota	2 000			
Residents of HC Fa Subd. 14. Freed Residents shall be defined in the Vulne "Maltreatment" me section 626.5572, s intentional and non physical pain or injuconduct intended to distress. Every res non-therapeutic ch except in fully docu authorized in writin resident's physician period of time, and protect the residen others. This MN Requirem by: Based on interview facility failed to ensure reviewed (R1) was a nursing assistant	ac.Bill of Rights om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the -therapeutic infliction of ury, or any persistent course of p produce mental or emotional sident shall also be free from emical and physical restraints, imented emergencies, or as g after examination by a n for a specified and limited only when necessary to t from self-injury or injury to ent is not met as evidenced r and document review, the sure one of five residents free from maltreatment when	21850			
	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER PROVIDENCE HEALTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa http://www.health.s obul.htm The Stat delineated on the a Department of Hea electronically. Althous necessary for State the word "corrected Then indicate in the process, under the date your orders wi electronically subm Department of Hea MN St. Statute 144 Residents of HC Fa Subd. 14. Freed Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, s intentional and non physical pain or injuce conduct intended to distress. Every res non-therapeutic ch except in fully docu authorized in writin resident's physiciar period of time, and protect the resident others. This MN Requirem by: Based on interview facility failed to ensi- reviewed (R1) was	OF CORRECTION         IDENTIFICATION NUMBER:           00339         00339           PROVIDER OR SUPPLIER         STREET AD           PROVIDENCE HEALTH CENTER         312 EAST           VANHOE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 1         http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm           http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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 "corrected" 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.           MN St. Statute 144.651 Subd. 14 Patients & Residents shall be free 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. <td>IT OF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLI A. BUILDING:         IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:       (X2) MULTIPLI A. BUILDING:         IDENTIFICATION NUMBER:       ID         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, S 312 EAST GEORGE S' IVANHOE, MN 56142         PROVIDENCE HEALTH CENTER       312 EAST GEORGE S' IVANHOE, MN 56142         IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 1       2 000         http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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 'corrected" in the box available for text. 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Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00339		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		СОМ	(X3) DATE SURVEY COMPLETED C 04/18/2017	
PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
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Findings include:						
admission record i	dentified diagnoses of					
11/7/16, indicated assistance with ac The Brief Interview score dated 11/7/1	R1 required extensive tivities of daily living (ADL's). of or Mental Status (BIMS) 6, identified R1 had severe					
indicated nursing a registered nurse (F hand when R1 gra later, NA-D brough bleeding skin tear slap. RN-D and th cleaned the 3.6 ce	assistant (NA)-F reported to RN)-D he/she slapped R1's bbed NA-F's arm. Seconds it R1 to RN-D to assess a on R1's right hand from NA-F's e director of nursing (DON) ntimeter (cm) long skin tear					
at 10:15 a.m. and assistance with ge wheelchair. NA-F and while attempting rabbed NA-F's let NA-E stated NA-F and forcefully slap making a loud nois NA-F replied aggre	established NA-E requested tting R1 to sit down in his/her entered R1's room to assist ng to get R1 to sit down, R1 ft forearm with the right hand. took his/her open right hand ped the top of R1's right hand, se. "R1 said "ow that hurts." esively to R1, "you don't grab					
	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER PROVIDENCE HEALT SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa nursing assistant s hand causing a ski Findings include: R1's medical recor admission record i dementia, Parkinso anxiety disorder. R1's quarterly Mini 11/7/16, indicated I assistance with ac The Brief Interview score dated 11/7/1 cognitive impairme R1's nursing progr indicated nursing a registered nurse (F hand when R1 gra later, NA-D brough bleeding skin tear slap. RN-D and th cleaned the 3.6 ce and applied 5 steri An interview with N at 10:15 a.m. and massistance with ge wheelchair. 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Minnesc	ta Department of He	ealth				
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00339	B. WING		C 04/18/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
DIVINE F	PROVIDENCE HEALT	HCENTER	T GEORGE S E, MN 56142	ST PO BOX 136		
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21850	was peeled back. desk to report the in assess the skin tea to report NA-F's tree An interview with the (SSD) was conduct The SSD stated the facility's Vulnerable NA-F, prior to susp of the facility that sa An interview with the conducted on 2/8/1 administrator stated on the Vulnerable A indicates Divine Pro- abuse of any reside the police, physicia incident. An interview with R 2:15 p.m. R1 state and caused a 1 1/2 NA-F's fingernail with An interview with R 2/10/17, at 12:55 p. brought R1 to the m attention for a bleed right hand. RN-D u bleeding and clean cm long. RN-D and strips to close the sa	NA-E took R1 to the nurses incident and have RN-D ar. NA-E then went to the DON eatment towards R1. The social service designee ted on 2/8/17, at 1:20 p.m. The DON and SSD reviewed the ending and escorting NA-F out ame day. The administrator was 7, at 1:45 p.m. The d staff receive annual training Adult Policy, and the policy povidence will not condone ent. The administrator notified n and R1's family of the 1 was conducted on 2/8/17, at d that NA-F slapped his hand that NA-F slapped his hand clinch tear on his hand when ent under his skin. N-D was conducted on .m. RN-D stated NA-E purses desk for medical ding wound on the top of his used gauze to stop the the skin tear measuring 3.6 d the DON applied five steri skin tear.	t			
Minnesota D	admitted to slappin frustration. The DC	n. The DON stated NA-F g R1 on the right hand due to DN notified the administrator, stigation, and terminated NA-F				
STATE FOR	-		6899	UYSK11	If continu	ation sheet 4 of 6

Minneso	ota Department of He	ealth		·····	-	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	PROVIDENCE HEALT	H CENTER	, MN 56142	Т РО ВОХ 136		
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21850	Continued From pa	age 4	21850			
	on 1/18/17 .					
	at 10:50 a.m. NA-I to sit down in the w left forearm with his top of R1's right ha then pried the resid go of the forearm. wrong and reported					
	to attend training s indicated NA-F atte training. A Divine F Employee Certifica by NA-F when hire had been provided Divine Providence Compliance Code	"mandatory for all departments ession" dated 7/19/16, ended Vulnerable Adult review Providence Health Center ation of Compliance was signed d on 3/18/14 indicated NA-F with education regarding Health Center's Corporate of Conduct and understood the porate Compliance Program.				
	1/19/17, indicated facility policy in reg Resident's rights a was terminated eff The "Divine Provid Adult Abuse Preve	ervisor Conference letter dated on 1/18/17, NA-F violated gard to Vulnerable Adults and nd due to the violation NA-F ective 1/18/17. lence Health Center Vulnerable intion Plan" last revised on buse as conduct which is not				
	an accident or ther or could reasonabl physical pain or inj including but not lir Hitting, slapping, k corporal punishme	rapeutic conduct with produces by be expected to produce fury or emotional distress, mited to, the following: icking pinching, biting or				

Minneso	ta Department of He	ealth				
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21850	Continued From pa	age 5	21850			
	The director of nur the VA policy and p education. The dir	sing or designee, could review procedures and provide staff rector of nursing or designee, dom audits to complete.	,			
	TIME PERIOD TO days	CORRECT: Twenty-one (21)				
Minnesota D STATE FOR	epartment of Health M		6899	UYSK11	If continuation sheet 6 of 6	