Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54277487M
Compliance #: H54273702C

Date Concluded: February 13, 2024

Name, Address, and County of Licensee Investigated:
Bethesda
901 Willmar Avenue SE
Willmar, MN, 56201
Kandiyohi County

Facility Type: Nursing Home

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Inconclusive

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):
The alleged perpetrator (AP), a staff member, abused the resident when the AP put a washcloth into the resident's mouth while assisting with cares.

Investigative Findings and Conclusion:
The Minnesota department of Health determined abuse was inconclusive. There were conflicting reports of what occurred. An unlicensed staff member stated the AP put a washcloth into the resident's mouth while providing care, the AP denied the allegation. The resident could not be interviewed due to his cognitive impairment, and there was no other evidence to support the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the law enforcement report. The investigation included review of the resident's record, federal survey notes, the facility internal investigation, and personnel records.

The resident resided in a nursing home. The resident's diagnoses included Alzheimer's disease, dementia, and a stroke affecting the resident's right side. The resident's care plan included assistance with bathing, a mechanical lift for transfers, dressing, grooming, and toileting. The resident's cognition was severely impaired.

The facility internal investigation indicated unlicensed personnel (ULP) said she assisted the AP with the resident providing care after a shower. The ULP heard the resident repeat saying "hey" throughout the shower which was normal behavior for him. During cares in the resident's room, the resident was still calling out. The AP got annoyed with the resident's calling out and verbalizations. The AP put a washcloth into the resident's mouth. The ULP said the washcloth was in the resident's mouth for five to ten minutes, and the resident still talked although muffled. The ULP said she took the washcloth out of the resident's mouth before leaving the resident's room. When asked if the resident could lift his good arm to his face to remove the washcloth, the ULP said sometimes, but not really.

The facility investigation indicated; the AP said the resident was calling out "hello" while preparing the resident for a shower. The AP and ULP moved the resident to the shower room and the AP gave the resident a shower. The resident was agitated throughout the shower and the AP said she tried to calm the resident. The AP said to calm residents she played music, put something on television, or tried to reason with them. Both the AP and ULP provided the resident care before and after the shower. The AP denied putting a washcloth into the resident's mouth to muffle the resident's calling out.

The resident's records indicated following the report of the incident, a nurse conducted an oral assessment. The resident showed no signs of bleeding, open areas or sores, the resident's gums were pink, no swelling noted, and the gag reflex was present. The resident was confused and not able to answer when asked about any pain in his mouth or neck. The resident had no distress, labored breathing, or injury. The resident's record indicated the resident had no change in mood or behaviors during the facility monitoring.

During an interview, a nurse stated she was notified by the ULP of the AP putting a washcloth into the resident's mouth. The nurse stated she contacted leadership and completed an oral assessment on the resident. The nurse stated, the resident had no oral injuries.

During an interview, leadership stated during the investigation, the ULP reported the alleged incident, and the AP denied the alleged incident occurred. Leadership stated there were no concerns raised from staff or residents during their internal investigation regarding the AP's care or interactions with residents. There was no camera footage of the alleged incident, or other witnesses.

When contacted, the ULP refused an interview.

During an interview, the AP stated the day of the alleged incident, when the resident was calling out, she provided reassurance, told the resident he was okay, explained they would be done with cares soon, and explained to the resident what cares she was providing. The AP denied the allegation and said she did not put a washcloth into the resident's mouth while providing cares.

The law enforcement report indicated the report was sent to the prosecutor for review.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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;
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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation, assessed the resident for injury, monitored, and offered the resident chaplaincy visits and psychiatry services. The facility provided additional training to all staff. The AP is no longer employed at the facility.

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
	00792	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(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 #H54277487M, #H54277505M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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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		