Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54277505M
Compliance #: H54273722C

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, emotionally abused a resident when the AP called the resident "stupid" and a "bitch" while providing care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was inconclusive. The AP and a witness (unlicensed personnel) provided conflicting reports of the incident. The ULP said the AP called the resident "stupid" and a "bitch", and the AP said the unlicensed personnel told the resident to "shut up." There were no other witnesses to the alleged incident and the resident could not be interviewed due to cognitive impairment. In addition, the alleged comments did not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident records, federal survey notes, the facility internal investigation, and the AP's and the ULP's personnel records.

The resident resided in a nursing home. The resident's diagnoses included Alzheimer's disease and dementia. The resident's care plan included assistance with transfers using two staff and mechanical lift. The resident's cognition was severely impaired, and the resident was not able to verbalize or respond to questions.

The facility investigation indicated the AP said she and the unlicensed personnel were assisting the resident to get ready for bed. The AP assisted with the resident's legs and the unlicensed personnel assisted with the resident's upper body. The AP said the resident grabbed her arms and the AP needed to pull the resident's hands off to continue to assist with the transfer. The AP denied calling the resident "stupid" or calling the resident a "bitch." The AP said the resident was calling out during the transfer and the unlicensed personnel assisting the AP told the resident to "shut up."

The facility investigation indicated both the unlicensed personnel and AP were assisting the resident with a transfer. The resident grabbed the AP's arm while they were attempting to get the resident positioned into a mechanical lift. The unlicensed personnel said the AP said to the resident "You're so stupid [name of resident]" and after pulling the resident's hand off the AP's arm said, "You don't need to be a bitch [name resident]." The resident was not interviewed due to cognition. Additional staff and residents were interviewed and there were no concerns about the AP and the unlicensed personnel's interactions with other residents and staff.

The resident's record did not indicate any changes with the resident's mood or behaviors during staff monitoring after the alleged incident. The facility nurse assessed the resident and there were no injuries or bruising identified.

During an interview, the AP denied she called the resident "stupid" and a "bitch." The AP said she did not remember if the unlicensed personnel swore at the resident but remembered the unlicensed personnel "yelling" and was "pretty sure" the unlicensed personnel called the resident "stupid."

During an interview, the unlicensed personnel said the AP called the resident "stupid" and a "bitch." The unlicensed personnel denied telling the resident to "shut up."

During an interview, leadership stated there was conflicting reports of what occurred between the AP, the unlicensed personnel, and the resident. Leadership stated there was no camera footage of the alleged incident or other witnesses. Leadership stated due to the resident's cognition, the resident was unable to recall the incident.

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;
(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: No. Due to cognition.
Family/Responsible Party interviewed: No, attempted but did not reach.
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 and unlicensed personnel (witness) are 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		