Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54464666M **Date Concluded:** May 1, 2023

Name, Address, and County of Licensee Investigated:
Assumption Home
715 North First Street
Cold Spring, MN 56320
Stearns 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 alleged perpetrator (AP), facility staff, neglected a resident when the AP turned off the resident's call light and failed to assist the resident with repositioning. The resident experienced pain and was emotionally distressed when her feet remained pressed against the footboard of her bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The resident requested assistance with repositing in bed due to pain. The resident turned on her call light for assistance with repositioning, however, the AP entered the resident's room and turned off the call light off without assisting the resident. The resident was in pain due to the lack of assistance with repositioning.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the previous federal investigation documents, incident reports, facility investigation documentation, staff/resident interviews and statements, AP disciplinary and training records, resident medical records, and facility policy and procedures.

The resident resided in a nursing home with diagnoses including restless leg syndrome, knee pain, low back pain, osteoarthritis, cognitive communication deficit, spinal stenosis, and Ankylosing Spondylitis (inflammatory arthritis affecting the spine and large joints).

The resident's care plan indicated the resident had a self-care deficit related to impaired mobility and lower extremity weakness and required staff assistance with bed mobility. The care plan indicated the resident should be repositioned every three hours and as needed (PRN). The care plan identified the resident had aphasia (difficulty finding words) and indicated staff should allow the resident time communicating wants/needs.

An incident report indicated when morning shift arrived the resident's call light was on. Staff went to assist the resident with morning cares and the resident was crying. The incident report indicated the resident put her call light on to request staff assistance with repositioning, but was unable to verbalize her needs to the AP. The report indicated the resident put her call light on four more times and the AP turned off the call light from the desk without entering the resident's room or addressing her needs.

The resident's toileting and repositioning documentation indicated staff were directed to reposition the resident every three hours and PRN. The AP documented the resident was sleeping and no repositioning was provided the night of the incident.

When interviewed staff stated the resident had a difficult time communicating her needs. The staff indicated the resident was a reliable reporter and had never reported concerns of neglect prior to that day.

A staff stated the morning of the incident she entered the resident's room to respond to the residents call light. Upon entering the resident's room, the resident was distraught, crying hysterically, and kept saying "That lady, that lady, she is a monster!" The staff stated the resident slid down in bed, her head was elevated, her feet were pressed against the foot board, and the residents' knees were in a locked position. The staff stated the resident complained of

pain in her legs and stated the AP would not help her. The staff stated the resident remained upset about the incident through the morning and did not want the AP in her room anymore.

The facility interviewed the resident following the incident and the resident reported she pressed her call light for staff assistance to reposition in bed because she was in pain. The resident stated the AP came to her room, turned off the call light, and left the room without providing any assistance to the resident. The resident stated she activated her call light several more times, but the AP turned off the call light from the desk and didn't come to the resident's room to assist the resident.

A review of the AP's personnel files included previous reports of the AP failing to reposition residents and turning off residents call lights without reporting a resident had pain. The AP received additional coaching and education on repositioning residents.

When interviewed the AP stated she did not reposition the resident every three hours as care planned because she thought the resident did not want to be bothered during the night. The AP stated when the resident called for assistance, the resident got frustrated because the AP could not understand her, so the AP left the room. The AP stated the resident called again for assistance, and the AP turned off the resident's call light at the desk. The AP stated when the resident turned her call light on again, she responded to the resident's room, but the resident told her to leave. The AP stated after that she let the resident's call light ring until the next shift came on duty, then she left the facility.

Facility leadership stated the AP did not follow the residents care plan to assist the resident with repositioning, and then repeatedly turned off the residents call light without ensuring the resident's needs were met. As a result, the resident's feet remained pressed against the footboard causing the resident to holler out and cry due to unrelieved pain.

When interviewed the resident's family member stated the resident was very upset because she had leg pain and staff failed to assist the resident with repositioning. The family member stated when staff assist the resident with repositioning that usually relieves her pain.

During a previous interview during the federal investigation, the resident stated the AP turned off her call light and did not assist the resident to boost up in bed. The resident stated she had severe pain in her legs, was crying in pain, and did not know how long she laid in that position before she got help.

In conclusion, neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, unable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP, investigated the allegation, and provided facility wide education on following a care plan and repositioning. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
Cold Spring City Attorney
Cold Spring Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00624	A. BUILDING: _____ B. WING _____	C 04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

(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 #H54464666M and H54464885M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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2 000	Continued From page 1 #H54464666M and #H54464885M tag identification 1850. 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	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	21850		

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21850	Continued From page 2 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. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 2 of 2 residents (R1, and R2) reviewed were free from maltreatment. R1 was neglected, and R2 was abused. Findings include: The Minnesota Department of Health (MDH) issued a determination that abuse occurred, and an individual staff person(s) were responsible for the maltreatment, in connection with incidents which occurred at the facility. 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.	