Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54822522M
Compliance #: H54821161C

Date Concluded: April 29, 2024

Name, Address, and County of Licensee Investigated:
Prairie Manor Care Center
220 Third Street NW
Blooming Prairie, MN 55917
Steele County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual responsibility

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, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The resident was abused when the alleged perpetrator (AP) refused to adjust the height of the lift arms on the mechanical lift for the resident's comfort. Then the AP taunted the resident in a confrontational and threatening manner causing the resident to "fear for her life" and repeatedly yell out in distress.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP emotionally abused the resident when the AP was aggressive and threatening when transferring the resident with the mechanical standing lift. The AP threatened to leave the resident suspended in the lift and responded to the residents' requests for another staff to provide cares in a threatening aggressive manner. The AP came in and out of the resident's room several times the evening of the incident and continued to harass and threaten the resident. The resident was yelling out for other staff and the resident stated she feared for her life.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), facility internal investigation, personnel files, staff schedules, previous federal investigation documentation, and related facility policy and procedures.

The resident resided in a nursing home with diagnoses including congestive heart failure, arthritis, radiculopathy - lumbar region (a spinal condition characterized by pain, tingling, or weakness that originates in the lower back and radiates down one or both legs), and chronic kidney disease stage 3.

The resident's assessment indicated the resident had no cognitive impairment was able to make her needs known. The assessment indicated the resident had frequent joint pain and was only able to stand with staff assistance. The resident was dependent on one staff for transfers and toileting using a mechanical sit to stand lift. The assessment indicated the resident had no behaviors at the time the incident occurred.

The facility investigation indicated the resident reported to several staff when the AP responded to the resident's request for assistance transferring to the toilet, the AP raised the residents' arms up too high with the mechanical lift. When the resident asked the AP to lower the lift, the AP became defensive and snapped at the resident "I am sick of you criticizing me and telling me how to do my job!" Then, the AP lowered the lift arms to a seated position and told the resident "Maybe I should leave it in this position and see how you feel about that?" The investigation indicated the AP argued with the resident and the resident told the AP to leave and requested another staff to help her. When the resident rang for assistance to get off the toilet, the AP responded to the resident's call light and said, "Guess who?" The resident repeated she did not want the AP, and asked for another staff to assist her, but the AP refused, and the resident began to holler loudly. The resident again expressed she did not want the AP to work with her, and the resident reported she felt unsafe, threatened, and feared for her life. When interviewed by the facility the AP denied threatening to leave the resident suspended in the lift and denied entering the resident's room after the resident asked for another staff to assist her. The facility investigation indicated leadership reviewed video surveillance footage showing the AP repeatedly returning to the resident's room 4 times after the resident asked the AP for another staff to assist her. One of the times the AP was observed exiting the resident's room, then turned back towards the doorway with tense body language, raised her arm and pointed angerly into the room, then walked away quickly. The investigation indicated the AP's statement of not entering the resident's room after the incident occurred was untruthful, and the facility incident they determined the AP abused the resident.

A progress noted the day of the incident indicated the resident refused restorative therapy due to being upset due to the incident with the AP.

A previous federal investigation indicated when interviewed the resident stated the AP raised her up too high in the lift, and the resident was on her tip toes and it hurt her arms, so the resident asked the AP to lower the lift a bit. The AP responded to the resident “I'm sick and tired of you telling me what to do all the time!” Then threatened the resident by saying “I should put you up there and let you dangle!” The resident stated she told the AP to send someone else to help her, and when the resident rang her call light the AP returned and said in a taunting manner, “Guess who!” The resident reported to the federal investigator she never felt so vulnerable or afraid and yelled as loud as she could till the AP left.

When interviewed several facility staff stated the resident was visibly distressed and crying after the incident occurred because the AP was verbally aggressive and threatening toward the resident causing her to be fearful. The staff members stated the resident was a reliable reporter.

When interviewed facility leadership stated the resident was extremely upset following the incident and expressed feeling distressed, scared, and threatened by the AP. Leadership staff stated the statements from staff were consistent with the residents, and the AP was defensive, sarcastic, rude, and not truthful when asked about the incident. Leadership staff stated the resident was a reliable reporter.

When interviewed the resident’s family member stated after the incident, the resident sounded scared and was crying. The family member stated the AP threatened to raise the resident up in the lift and leave her hanging from the lift. The family member stated the resident told the AP to leave and not come back, but the AP refused and continued responding to the resident’s call light in a harassing manner by saying “I’m back, what are you going to do about it?” The family member stated the incident affected the resident and made her feel afraid for months after the incident occurred.

When interviewed the resident stated the AP was abusive to her. The resident stated when the AP was assisting the resident to the bathroom, the AP hooked the resident up to the sit to stand mechanical lift, and then raised the resident up only a fourth of the way. The resident stated she told the AP the lift wasn’t high enough and her feet were going to slip. The resident stated the AP responded by raising the lift arms of the mechanical lift up so high it pulled on her arms and she was on her tip toes. The resident asked the AP to lower the lift and the AP responded in an angry tone “I am sick and tired of you telling me what to do”. The resident stated she told the AP to stop giving her attitude, and the AP threatened the resident and said “Oh, you’ll be surprised what you’re gonna get, I think I will raise you up and put you in the middle of the room and let you dangle there a while!” The resident stated the AP put her on the toilet, and she told the AP to leave and not come back. The resident stated when she put on her call light for help to get off the toilet the AP returned and said in a threatening manner, “Guess who’s back!” The resident stated, “I was so scared, I started yelling for help, the AP shut the door and I kept yelling until someone came to help me!” The resident stated she repeatedly told the AP to leave her room and not come back, but the AP just laughed at her and refused to leave. The

resident stated when another staff responded and took over, the AP angerly stood in the hallway. The resident stated she felt threatened and scared by the way the AP treated her, and explained there was no way she could call for help if the AP left her suspended from the lift in the middle of the room. The resident stated the AP repeatedly came back in her room to taunt her after being told to leave causing her distress. The resident was tearful and distressed while talking about the incident which occurred several months prior to interview.

During a phone interview attempt the AP was verbally aggressive and refused to be interviewed. Although the AP refused to be interviewed, the AP did state, “I put the resident up in the air, she said it was too high and asked to be put down. I told the resident I could not put her down anymore because she would not clear the toilet, then the resident made up a bunch of crap.”

In conclusion, the Minnesota Department of Health determined abuse 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.

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;
(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: Refused

Action taken by facility:
The facility ensured the resident was safe, suspended the AP, reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), and investigated the incident. 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.

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

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
Steele County Attorney
Blooming Prairie City Attorney
Blooming Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00650	A. BUILDING: _____ B. WING _____	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

(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: On April 22, 2024, the Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54822522M/#H54821161C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000		

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2 000	Continued From page 1 The following correction order is issued for #H54822522M, 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		
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 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.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure one of one resident (R1) was free from maltreatment. The findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	21850		