Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55072482M **Date Concluded:** December 23, 2022

Name, Address, and County of Licensee Investigated:
Hillcrest Health Care LLC
714 Southbend Avenue
Mankato, MN 56001
Blue Earth County

Facility Type: Nursing Home

Evaluator's Name:
Lisa Coil, RN Special Investigator

Finding: Not Substantiated

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) abused the resident when the AP posted a video of the resident on social media.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP may have acted facility policy by creating and possibly posting the video, there was a lack of evidence to indicate the resident suffered emotional abuse.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator conducted an interview with the resident's family member and the AP. The investigator reviewed the resident's medical record, the AP's training record, and the facilities internal investigation.

The resident resided in a nursing home and received hospice care services. The resident's diagnoses included dementia with behavioral disturbances and anxiety. The resident's care

plan indicated the resident required assistance with all daily cares. The resident's assessment indicated the resident had severe cognitive impairment, which meant she had a very hard time remembering things, making decisions, or concentrating.

Review of a video clip showed a female in a blue scrub top, wearing a light blue surgical mask with her hair pulled back. The video showed the female's eyes then the camera turns to a bed where a female resident is sleeping. The female is lying on her back with both hands behind her head, the blankets are pulled up to the middle of her stomach area. The video goes back to the females face and ends. The female does not say anything but there is background noise heard on the video.

Review of a second video clip showed the same female from the first video clip. In this video, the female was not wearing surgical mask. The female is walking in the facility while laughing and talking. The female stated to someone "how's my favorite human doing in the whole wide world?" Someone is heard responding to her, but no face is shown on the video clip.

Review of the resident's medication record did not indicate the resident had a change in medications or medication usage following the incident. Review of the resident's nurse progress notes did not indicate the resident had changes in behavior following the incident.

During an interview, the AP, also an unlicensed personnel (ULP), stated the registered nurse (RN) escorted her out of the building for breaking for posting a video or something. The AP stated she asked the RN to see this video or whatever the RN was talking about, but the RN did not show it to the AP. The AP denied posting videos of residents on social media.

During an interview, the family member stated he never had a conversation with the resident regarding the incident. FM stated the resident was not able to understand things very well and would have a tough time recalling details to the incident. FM stated he did not notice any behavior changes following the incident.

During an interview, an administrative staff member (ADM) stated another ULP saw the video clip on the AP's social media account and reported the incident. The AP was immediately removed from her shift and suspended during an investigation of the incident. The ADM stated there was no malicious harm caused to the resident.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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. Unable to be interviewed.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and followed their policies and procedures related to the incident. The facility provided re-training for all staff related to Vulnerable Adult Maltreatment.

Action taken by the Minnesota Department of Health:
No further action at this time.

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
	00031	A. BUILDING: _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

(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 #H55072482M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00031	A. BUILDING: _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE & REHABILITATION CENTE	714 SOUTHBEND AVENUE MANKATO, MN 56001

(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	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		