Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55294063M **Date Concluded:** August 21, 2023

Name, Address, and County of Licensee Investigated:
Bigfork Valley Communities
258 Pine Tree Drive
Big Fork, MN 56628
Itasca County

Facility Type: Nursing Home

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

Finding: Not Substantiated

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 alleged perpetrators (AP-1 and AP-2) abused the resident when AP-1 yelled at the resident and told the resident to shut up and eat, and AP-2 asked to put duct tape on the resident's mouth and then laughed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. AP-1 responded to the resident in a rude inappropriate way, however, it was an isolated incident, and the incident did not rise to the level of abuse. AP-2's statement about duct tape was not directed at the resident and was not heard by other residents.

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 resident assessments, care plan, progress notes, incident

reports, facility investigation documentation, and interviews. In addition, the investigator reviewed previous survey documentation.

The resident's assessment indicated the resident was cognitively impaired with short term memory loss, confusion, and forgetfulness, but could make her needs known.

The resident's care plan indicated the resident had verbal behaviors including asking repetitive questions, hollering at staff, and yelling for help. The care plan indicated at times the resident would continue to holler despite all interventions tried and directed staff to place the resident in her room and close the door so other residents and family did not get upset.

The facility investigation indicated during the evening meal the resident yelled the meal was disgusting and asked for soup. Interviews with witnesses indicated the resident was provided soup but continued screaming and yelling for salt. AP-1 responded to the resident in a harsh tone of voice that they did not have salt, and "please shut up and eat." The facility investigation indicated after the resident left the dining room AP-2 said, "do I have permission to duct tape her mouth." However, when interviewed no other staff or residents heard the statement, and AP-2 denied making the statement.

When interviewed staff indicated the resident had very difficult disruptive behaviors and continuously yelled. Staff stated the resident's behaviors were constant and very stressful to deal with and indicated one day AP-1 responded in a tone of voice that was rude. Staff indicated it was an isolated incident and AP-1 had never responded to the resident like that before. Staff stated the resident was not affected by AP-1's statement or tone of voice, continued to yell out, then had to be brought to her room because of ongoing disruptive behavior as care planned. One staff stated after the resident was brought to her room, she heard AP-2 make a comment about putting duct tape on the resident's mouth.

When interviewed leadership staff stated AP-1 responded to the resident with poor customer service in a rude inappropriate tone of voice. Leadership staff indicated it was a brief isolated incident and AP-1 had no other conduct concerns. Leadership staff indicated if AP-2 made a comment about duct tape it was after the resident had left the dining room, and no other staff or residents heard it.

When interviewed AP-1 denied the allegation of abuse.

AP-2 did not respond to interview requests.

In conclusion, 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.
Family/Responsible Party interviewed: No, did not respond to interview attempts.
Alleged Perpetrator interviewed: Yes AP-1, AP-2 did not respond to interview attempts and/or subpoena.

Action taken by facility:
The facility suspended the AP's, reported the allegation to the common entry point, and investigated the incidents.

Action taken by the Minnesota Department of Health:
No further action taken 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
	00834	A. BUILDING: _____ B. WING _____	C 08/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIGFORK VALLEY COMMUNITIES	258 PINE TREE DRIVE BIGFORK, MN 56628

(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 #H55294063M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	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.	

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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	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.	