Protecting, Maintaining and Improving the Health of All Minnesotans

Health Regulation Division
Investigative Public Report

Maltreatment Report #: H5594022M

Date Concluded: October 1, 2021

Name, Address, and County of Facility Investigated:
Gil Mor Manor
96 3rd St East
Morgan, MN 56266
Redwood County

Facility Type: Nursing Home

Evaluator's Name:
Lisa Coil, RN Special Investigator

Finding: Inconclusive

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 the applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The alleged perpetrator (AP) physically abused the resident when the AP hit the resident's head on the grab bar while turning the resident. It is also alleged the AP verbally abused the resident when the AP said, "that's what you get for being a bitch all night."

Investigative Findings and Conclusion:
It was inconclusive whether abuse occurred. While the resident did bump against the side rail during cares, there is conflicting information about how it occurred and how many times. There is also conflicting information regarding the statement attributed to the AP.

The investigation included interviews with facility staff members, including administrative nursing staff, and unlicensed staff. The investigator reviewed the resident's medical record, the AP's personnel file, and the facilities internal investigation record.

The resident's diagnoses included weakness, arthritis, anxiety, and depression. The resident's care plan indicated the resident required the assistance of two staff members to move in bed.

The same document indicated the client used grab bars to move in bed. The resident's medical record indicated she had forgetfulness and moderate cognitive loss.

The facility's internal investigation indicated the certified nurse assistant (CNA) reported the AP was rough with the resident during morning cares. The report indicated the CNA stated the resident complained her head was bumped, and it hurt. The report further indicated the CNA stated the resident asked the AP, "Why are you always so mean to me," to which the AP replied, "that's what you get for being a bitch all night."

During an interview, the CNA stated she was assisting the AP with washing the resident up for the day. The CNA stated the resident was in bed, while the CNA was standing by the resident's legs and mid-section and the AP was by the resident's shoulders and back. The CNA stated when she and the AP rolled the resident, the resident hit her head on the grab bar each of four times and the resident asked the AP why she was so mean. The CNA stated the resident was getting more upset each time. The CNA stated the last time the resident hit her head on the bar, the AP told her "That's what you get for being a bitch and being on your call light all night." The CNA stated she and the AP finished getting the resident dressed but the resident did not want to get out of bed, so the CNA and the AP walked out of the room. The CNA stated the resident was upset, would not get out of bed that day, and complained of a headache later that day and the next day. The CNA stated she went to the administrator's office two hours later to report the incident.

During an interview, the Director of Nursing (DON) stated she interviewed the resident in the afternoon on the day of the incident. The DON stated she asked the resident if her head bumped the grab bar while the CNAs helped turned her and the resident responded that she hit her glasses and expressed concern her eyeglasses became bent. The DON stated she asked the resident if she was hurt, and the resident said no. The DON stated she interviewed the resident again the next day and asked the resident if she recalled what happened the morning before, the resident responded that she remembered her face being bumped on the grab bar and expressed concern about her glasses. The DON stated the resident remembered hitting her head one time and the resident did not recall the AP making any statements to her. The DON stated the resident had no visible marks on her body, but the DON recalled the resident complained of pain the next day. The DON stated the resident had a history of arthritis and often complained of headaches. The DON stated the medication administration record and progress notes showed the resident took her regularly scheduled pain medications but no additional pain medications on the day of the incident nor the next day. The DON stated she interview the AP, who denied the allegations. The DON stated the AP had no other incidents related to resident care.

During an interview, the AP, who is a CNA, stated on the date of the alleged incident she worked the overnight shift and stayed the following morning to help with resident's morning cares. The AP stated she had gotten the top half of the resident washed up and partially dressed the resident prior to the CNA entering the room. The AP stated once the CNA arrived to

assist, they laid the resident back down on the bed and rolled the resident to her left side, washed the residents bottom, place an incontinent product, placed the lift sheet, rolled the resident to her right side, and did the same thing, then used a mechanical lift to get the resident up. The AP stated she did not recall any part of the resident's body hitting anything. The AP stated if any part of the resident's body hit something, she would have reported it to the nurse on duty for further monitoring. The AP denied saying, "That's what you get for being a bitch all night", to the resident.

The AP is no longer employed at the facility.

In conclusion, it was inconclusive whether abuse occurred.

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:
(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, resident deceased.
Family/Responsible Party interviewed: No, declined.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reviewed its maltreatment identification and reporting policies.

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

cc:
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 3/23/21 through 3/24/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5594020C (MN71031), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	2 000		