MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
REM Woodvale Inc. Adams
592 Adams Avenue
Owatonna, MN 55060
Steele County

Report#: HG385002

Date: December 22, 2015

Date of Visit: July 16, 2015
Time of Visit: 11:30 a.m. – 5:00 p.m.

By: Stephanie Richard, RN, Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☐ Home Care Provider
☐ SLF ☒ ICF/IID
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that clients were emotionally and physically abused when a staff, alleged perpetrator (AP) yelled and swore at the clients and physically pushed the clients.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☑ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☑ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:
Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☑ Abuse ☐ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of the evidence, abuse is substantiated when the alleged perpetrator (AP) physically pushed a client, forcefully administered medications to another client and was emotionally/verbally abusive to a third client.

Document reviews and interviews revealed the following incidents occurred during the second week of April, 2015 and each was reported to facility administration, by the witness according to policy.

Client #1 (C1) had been at the facility for many years, had severe intellectual disability, schizoaffective disorder, hip deformity and a colostomy. Assessments showed that C1 would not be able to defend her/himself against verbal/emotional or physical abuse. On the day of the incident, the AP was observed to approach C1 with medications while C1 was seated at the dining room table. The AP placed pills into C1's mouth and C1 spit the pills out, the AP retrieved the pills and while forcefully holding C1's head back, put all the medications into C1's mouth and poured a cup of liquid into C1's mouth. C1 choked and liquid ran out of both sides of his/her mouth.

C2 was at the facility for many years, had mild intellectual disability, cerebral palsy and epilepsy. C2 told direct support personnel that she wanted to apologize to the AP because of an earlier misunderstanding. A witness heard C2 trying to apologize to the AP and the AP was heard telling C2 that s/he was "f*****g pathetic."

C3 had moderate/severe intellectual disability, dementia, schizophrenia and a seizure disorder. One morning before C3 left for work a witnesses saw the AP in C3's room, with C3. C3 was trying to reach something in his/her closet, the AP was pushing C3 back so s/he was unable to reach whatever it was s/he was trying to get. The AP yelled at C3 to "shut up."

The AP was interviewed and denied ever telling C3 to shut up, swearing or pushing any client or forcefully administering medication to a client. On the occasion that C2 apologized to the AP s/he had to ask C2 what s/he was apologizing for because the AP did not recall any issue. The AP denied raising his/her voice and stated physical redirection of clients is not allowed at the facility. The AP remembered training related to the vulnerable adult law and that clients have rights to be free from abuse or neglect. The AP said staff is expected to be respectful of clients and treat all clients with dignity. The AP felt s/he treated the clients with dignity.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ individual(s) and/or ☐ facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place in regards to the Vulnerable Adult Law and reporting. The AP's personnel file identified the AP had training related to the Vulnerable Adult Law/reporting requirements. When interviewed, the AP confirmed s/he had been trained in the VA law and was aware of the definitions of abuse.

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.

Compliance:

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) – Compliance Not Met
The requirements under Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) – Compliance Not Met
The requirements under State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse
"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;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records	☒ Care Guide
☒ Medication Administration Records	☒ Treatment Sheets
☒ Facility Incident Reports	☐ Physician Progress Notes
☒ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☐ Social Service Notes
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records
☐ Therapy and/or Ancillary Services Records	☒ Assessments
☐ Skin Assessments	☒ Care Plan Records
☐ Service Plan	☐ Other, specify: _____

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☐ Resident/Family Council Minutes ☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: Unit

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 5

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 5

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☒ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☒ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A Specify: _____

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A Specify: _____

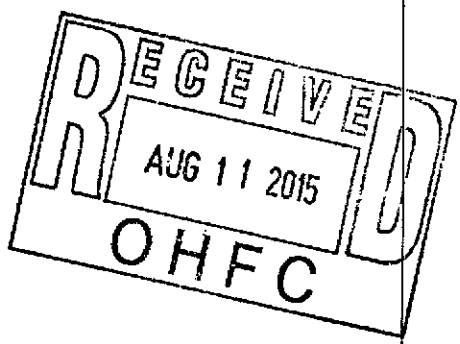
Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification
The Office of Ombudsman for Mental Health and Developmental Disabilities
Owatonna City Police Department
Steele County Attorney
Owatonna City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G385	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WOODVALE INC ADAMS	592 ADAMS AVENUE OWATONNA, MN 55060

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #HG385002. Please see federal survey dated 7/2/2015 for federal deficiencies.	W 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Stephanie Kalbach
Regional Director for Patricia Mosser Executive Director 8/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. A complaint investigation was conducted to investigate case #HG385002. As a result, the following correction order is issued.	5 000	RECEIVED AUG 12 2015 OHFC 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. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule	

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5 000	Continued From page 1	5 000	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 evidenced by." Following the surveyors findings are the Suggested Method of Correction and the 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.	
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS 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 nontherapeutic 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 nontherapeutic 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	5 700		

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5 700	Continued From page 2 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 document review and interviews, the facility failed to ensure 3 of 3 clients (C1, C2, C3), reviewed for maltreatment, were free from abuse when a staff was verbally, emotionally and physically abusive. Findings include: C1's medical record revealed that C1 was admitted to the facility on 1/1/95. C1 had Down's syndrome with severe intellectual disability, bilateral congenital hip deformity and a colostomy bag. C1's Risk Assessment, dated 8/14/14 showed that C1 is at risk as she would not be able to defend herself against physical and or verbal/emotional abuse. Due to physical mobility deficits, she would not be able to escape if physical abuse were to occur. C1 would not know how to report abuse if abuse occurred. C1 had a history of swearing at people and inappropriate behaviors of poking, licking and pinching others. C1's Action Plan dated 9/1/14, shows C1 had a goal to improve social relationships and develop socially appropriate coping behaviors. C1 had a goal to increase participation in medication administration in which she will complete hand washing prior to medication administration 95% of the time for 3 months. Facility incident Report dated 4/20/15 showed that on 4/19/15, direct support personnel (DSP)-E	5 700		

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5 700	Continued From page 3 called Program Director (PD)-B at 11:00 p.m. to report that she had witnessed DSP-H administer medications to C1 in an abusive manner, the document does not describe the abuse. C1's Medication Administration Record, dated 4/1/15 through 4/30/15, shows that C1 received 8 pills, orally, each morning. Two of the pills are TUMS which C1 takes first and chews before taking the 6 remaining pills. DSP-E was interviewed on 7/16/15 at 1:25 p.m. and stated that during the second week of April there were several incidents in which DSP-H acted inappropriately toward clients. DSP-E described that on 4/14/15 or 4/17/15, she saw C1 sitting at the kitchen table between 7:00 a.m. and 8:00 a.m., C1 was dressed and ready to leave for work. DSP-H approached C1 and put the medication cup of pills into C1's mouth, C1 spit out the pills and DSP-H picked them back up, tilted C1's head back forcefully with one hand on C1's forehead and poured all the pills into C1's mouth. DSP-H then took a Dixie cup of liquid and poured the contents into C1's mouth, C1 was choking and coughing with fluid running down the sides of her mouth. DSP-E nudged the DSP-H with her arm to move her out of the way and said to the DSP-H that she should take a break. C2's medical record showed C2 was admitted to the facility on 4/19/93 and had mild intellectual disability, cerebral palsy and epilepsy. C2's Risk Assessment, dated 4/16/15 showed that C2 is at risk of abuse related to not being able to defend herself. C2 is capable of reporting abuse but may be untruthful and not able to report when having seizure activity. C2 is unable to defend herself against verbal/emotional abuse.	5 700		

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5 700	Continued From page 4 C2 moves slowly and this may be frustrating for others. C2's Action Plan, dated 7/1/15, showed C2 had goals to increase responsibility for her adaptive equipment, increase independence in medication administration, increase social relationships and skills, complete physical therapy exercises independently, money management and domestic skills. C2's Individual Support Services Assessment, dated 5/14/15 revealed that C2 may not associate consequences with actions and had a tendency to become verbally aggressive, occasionally will hit a wall or herself but had no physical aggression toward others. Facility incident Report dated 4/20/15 showed that on 4/19/15 staff member DSP-E called PD-B at 11:00 p.m. to report that DSP-H pushed and swore at C2. DSP-E was interviewed on 7/16/15 at 1:25 p.m. and said she heard that C2 had hit DSP-H which was out of character for C2. C2 told DSP-E that DSP-H had pushed her. C2 told DSP-E she wanted to apologize to DSP-H for hitting her. DSP-E heard C2 approach DSP-H and DSP-H told C2 that they were no longer friends and C2 was "f...ing pathetic." DSP-D said when interviewed on 7/16/15 at 3:20 p.m. that when DSP-H works the clients are afraid to ask for anything like snacks or activities, DSP-H raises her voice towards the clients often. C3's medical record revealed that C3 was admitted to the facility on 2/14/91 and had moderate/severe intellectual disabilities,	5 700		

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5 700	Continued From page 5 dementia, schizophrenia and seizure disorder. C3's Risk Assessment, dated 4/16/15 showed C3 risks abuse due to not being able to defend himself or report to others if abused. C3 makes delusional statements at times. C3's Action Plan dated 6/30/15, showed C3 had a goal to manage symptoms of diagnosed schizophrenia and maintain appropriate social interactions and topics of conversation. C3's Individual Support Services Assessment dated 4/16/15 revealed that C3 is able to be redirected in most circumstances but due to symptoms of dementia will often forget he has asked a question and will ask the same question or make the same request repeatedly. C3 will boss staff around due to his impatience and forgetting that a question has been asked and answered. Facility incident Report dated 4/20/15 showed that on 4/19/15, DSP-E called PD-B at 11:00 p.m. to report that she had witnessed DSP-H push and yell "shut up" at C3. DSP-E was interviewed on 7/16/15 at 1:25 p.m. and on 7/22/15 at 2:55 p.m. and said she walked into the men's apartment one morning before C3 left for work and saw DSP-H with C3 in C3's room. C3 was trying to reach for something in his closet and DSP-H kept pushing him back so he could not get into his closet. DSP-H yelled at C3 to "shut up." C3 hit DSP-H as she physically pushed him out of the room. DSP-E said she then escorted C3 by the arm to the living room area. DSP-D stated when interviewed on 7/16/15 at 3:20 p.m. that DSP-H has a temper and if she	5 700		

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5 700	Continued From page 6 doesn't get all her work done or clients don't do something she has asked them to do, she gets frustrated and yells. DSP-H was interviewed on 7/17/15 at 9:36 a.m. and said C1 frequently spits out her pills but she never forced C1 to take medications, C1 drinks liquid independently and chews two TUMS before taking the other pills. C2 yells at staff because she gets frustrated, she did recall C2 wanting to apologize to her but DSP-H had to ask C2 what she was talking about. DSP-H denied ever yelling at C2, pushing or calling her "f...ing pathetic." C3 is non-compliant but if you give him a moment he will cooperate, physical redirection is not allowed at the facility. C3 repeats himself frequently but DSP-H denied ever telling C3 to shut up or pushing C3. DSP-H did not recall any one ever telling her she was causing stress for the clients and staff and she was not aware that she ever raised her voice. DSP-H stated the facility expectation is that every one is respectful and all clients are treated with dignity. DSP-H said she was aware of the vulnerable adult law and that abuse, whether verbal, mental, emotional or financial is not allowed. The Consumer Protection Handbook, dated 9/1/05, revised 8/18/14 defines abuse as conduct which is not accidental or involves non-therapeutic conduct, which produces or could reasonably be expected to produce physical pain, injury or emotional distress including but not limited to, 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 degrading, or the use of repeated or malicious oral, written or derogatory, humiliating, harassing, or threatening language.	5 700		

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5 700	Continued From page 7 Area Director (AD)-A was interviewed on 7/16/15 at 2:55 p.m. and said that staff receive training on the Vulnerable Adult law during orientation and twice a year during staff meetings they review key points of the law such as the definition of abuse, staff are given examples and told how to respond if they suspect abuse or neglect and what it means to be a mandated reporter. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	5 700		

AH Form Approved
9/11/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
01439	A. Building B. Wing	8/27/2015

Name of Facility	Street Address, City, State, Zip Code
REM WOODVALE INC ADAMS	592 ADAMS AVENUE OWATONNA, MN 55060

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 50700 Reg. # MN Statute 144.651 Subd. LSC	08/27/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/kfd		31242	08/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/24/2015			