Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL20199066M
Compliance #: HL20199067C

Date Concluded: January 13, 2020

Name, Address, and County of Licensee Investigated:
Hillcrest Terrace of Chisholm
624 SW 3rd Street
Chisholm, MN 55719
St. Louis County

Name, Address, and County of Housing with Services location:
Hillcrest Alice
2314 2nd Avenue East
Hibbing, MN 55746
St. Louis County

Facility Type: Home Care Provider

Investigator's Name: Paul Spencer RN
Special Investigator

Finding: Substantiated, individual responsibility

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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) abused the client when he used a physical restraint to keep the client in his wheelchair causing the client distress.

Investigative Findings and Conclusion:

Abuse was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP unnecessarily physically restrained the client in his wheelchair with a transfer belt. Another facility staff member found the client yelling for help and trying to remove the transfer belt.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included observation of the client and a review of his medical record. The investigation included a review of pertinent facility policies and procedures. The investigation included an interview with the AP.

The client's diagnoses included paranoid schizophrenia, history of alcohol abuse, and history of pacemaker placement. The client's service plan indicated the client required assistance with medication administration, toileting, transfers, fall precautions, and wheelchair assist. The service plan did not include the use of a physical restraint.

Review of facility documentation regarding the event indicated one evening the AP placed a transfer belt around the client's waist to prevent him from sliding out of his wheelchair during dinner.

During an interview, the AP stated he applied a transfer belt around the client's waist and secured the transfer belt around the back of the wheelchair to keep the client from sliding forward and falling out of his wheelchair. The AP stated the transfer belt looked similar to a back brace and he buckled the straps behind the back of the wheelchair. The AP stated that after he applied the transfer belt he left the client to help on the other side of the building. When asked if the client could have released the buckles to remove the transfer belt himself, the AP stated probably not. When asked if the client had an assessment or a physician's order for the use of the transfer belt in this way the AP stated he did not think so.

During an interview, unlicensed personnel (ULP)-F stated she worked on the other side of the building when she heard the client yelling for help. ULP-F stated she found the client with a transfer belt around his chest making it difficult for him to breathe and restraining him in his wheelchair. ULP-F stated the client was pulling at the transfer belt in an effort to remove it. ULP-F stated she had difficulty releasing the transfer belt from behind the back of the wheelchair. ULP-F stated she had an image of the client in the wheelchair with the transfer belt applied taken at the time of the event.

ULP-F provided an image for the investigation taken at the time of the event of the client restrained in his wheelchair. The image showed a transfer belt applied backwards around the client's chest and extending under his arms towards his back while a portion of the wheelchair frame was visible. ULP-F stated the client attempted to remove the transfer belt as indicated by his right hand pulling at the handle of the transfer belt in the image.

During an interview, ULP-D stated she saw the transfer belt applied around the client while in his wheelchair restricting the client's movement. ULP-D stated there was no physician order for the use of the transfer belt. ULP-D stated ULP-G said he put the transfer belt on the client to prevent him from sliding forward in the wheelchair and falling. ULP-D stated she told ULP-G he could not restrain the client without a physician's order.

During an interview, the facility manager stated the unlicensed personnel (ULP) working that evening included ULP-D, ULP-F, and the AP. The manager stated the AP told her he applied a transfer belt around the client's waist while in his wheelchair to keep the client from sliding out

of the wheelchair. The manager stated she did not see the transfer belt applied to the client because by then staff had removed the transfer belt and the client was in bed.

During an interview, the interim Director of Nursing (DON) stated the AP application of the transfer belt around the client while in the wheelchair violated the facility's policy on restraints. The DON stated the client did not have a nursing assessment for a restraint or a physician's order for a restraint as required by the policy. The DON stated the AP's use of the transfer belt in the wheelchair was also not consistent with manufacturer's instructions.

In conclusion, abuse was substantiated.

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:
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult;

Vulnerable Adult interviewed: Yes, attempted.
Family/Responsible Party interviewed: Not applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
ULP-F removed the restraint from the client.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
St. Louis County Attorney
Hibbing City Attorney
Hibbing Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On December 26, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL20199067C/#HL20199066M. At the time of the survey, there were #25 clients receiving services at the housing with service under the comprehensive license. The following correction order is issued/orders are issued for #HL20199067C/#HL20199066M, tag identification 0265.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 265 SS=G	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. (a) A person	0 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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
0 265	Continued From page 1 who receives home care services has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide a standard of care for one of one clients (C1) reviewed when a staff member applied a physical restraint in violation of the licensee's policies. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's diagnoses included paranoid schizophrenia, history of alcohol abuse, and history of pacemaker placement. C1's service plan dated July 30, 2019, indicated C1 required assistance with medication administration, toileting, transfers, fall precautions, and wheelchair assist.	0 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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
0 265	Continued From page 2 An incident report dated November 15, 2019, included an addendum dated November 18, 2019, which indicated unlicensed personnel (ULP)-G placed a transfer belt around C1's waist to prevent him from sliding out of his wheelchair during dinner. During an interview on December 27, 2019, at 10:25 a.m., Facility Manager (FM)-B stated on the evening shift of November 15, 2019, the ULP working included ULP-D ULP-F, and ULP-G. FM-B stated ULP-G told her he had applied a transfer belt around C1's waist while in a wheelchair to keep C1 from sliding out of the wheelchair. FM-B stated she did not see the transfer belt applied to C1 because by then staff removed the transfer belt and C1 was in bed. During an interview on January 6, 2020, at 5:26 p.m. stated ULP-G stated he worked on November 15, 2019, when he applied a transfer belt around C1's waist and secured the transfer belt around the back of the wheelchair to keep C1 from sliding forward and falling out of his wheelchair. ULP-G stated the transfer belt looked similar to a back brace and he buckled the straps behind the back of the wheelchair. ULP-G stated that after he applied the transfer belt he went to help on the other side of the building. When asked if C1 could have released the buckles to remove the transfer belt himself ULP-G stated probably not. When asked if C1 had an assessment or a physician's order for the use of the transfer belt in this way ULP-G stated he did not think so. During an interview on December 31, 2019, at 10:12 a.m., ULP-F stated she worked on November 15, 2019, on the other side of the building when she heard C1 yelling for help.	0 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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
0 265	Continued From page 3 ULP-F stated she found C1 with a transfer belt around his chest making it difficult for him to breathe and restrained him in his wheelchair. ULP-F stated C1 was pulling at the transfer belt in an effort to remove it. ULP-F stated she had difficulty releasing the transfer belt from behind the back of the wheelchair. ULP-F stated she had an image of the client in the wheelchair with the transfer belt applied taken at the time of the event. On December 31, 2019, at 10:25 a.m., ULP-F provided an image she stated taken on November 15, 2019, of the transfer belt applied to C1 in his wheelchair. The image showed a transfer belt applied backwards around C1's chest and extending under his arms towards his back while a portion of the wheelchair frame is visible. ULP-F stated C1 attempted to remove the transfer belt as indicated by his right hand pulling at the handle of the transfer belt in the image. During an interview on December 31, 2019, at 1:29 p.m., ULP-D stated she saw the transfer belt applied around C1 while in his wheelchair restricting C1's movement. ULP-D stated there was no physician order for the use of the transfer belt. ULP-D stated ULP-G said he put the transfer belt on C1 to prevent him from sliding forward in the wheelchair and falling. ULP-D stated she told ULP-G he could not restrain C1 without a physician's order An undated facility-provided policy titled Physical Restraints indicated before a physical restraint is applied the Registered Nurse (RN) will complete an assessment to determine what behavior the resident is exhibiting requiring the use of a physical restraint. The same document indicated if a restraint is needed, the RN will contact the	0 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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
0 265	Continued From page 4 client's physician and, if the physician agrees, obtain a physician order. The same document indicated the RN would update the client's service plan implementing the use of a physical restraint. During an interview on January 2, 2019, at 12:10 p.m., Interim Director of Nursing (DON)-C stated ULP-G applied the transfer belt around C1 while in the wheelchair it violated the facility's policy on restraints. DON-C stated C1 did not have a nursing assessment for a restraint or a physician's order for a restraint as required by the policy. A review of the client's signed service plan dated July 30, 2019, did not include the use of a physical restraint. TIME PERIOD FOR CORRECTION: Seven (7) days	0 265		
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused.	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20199	A. BUILDING: _____ B. WING _____	C 12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE OF CHISHOLM	624 SW THIRD STREET BOX 552 CHISHOLM, MN 55719

(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
0 325	Continued From page 5 Findings include: On January 13, 2020, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		