MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Neilson Place

Facility Address:
1000 Anne Street NW

Facility City:
Bemidji

State: Minnesota
ZIP: 56601
County: Beltrami

Report Number:
H5039013

Date of Visit:
February 14, 15, and 16, 2017

Time of Visit:
6:00 p.m. to 8:30 p.m.
8:00 a.m. to 4:30 p.m.
8:00 a.m. to 1:15 p.m.

Date Concluded:
April 17, 2017

Investigator's Name and Title:
Jessica Sellner, RN

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was emotionally abused by staff when staff asked the resident questions about whether or not the camera in the residents room was on.

It is alleged that a resident was neglected when staff left the resident wet and soiled without providing assistance to the resident and the resident had bedsores in areas covered by the incontinence brief. The resident required a specific sling for transfers which has not been ordered resulting in the resident almost falling out of the sling during a transfer.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when, under the direction of administration, facility staff constantly questioned the resident, significantly decreased interactions with the resident, and treated the resident differently after the resident installed a video camera in their private room to feel safe. Facility staff were directed by administration to ask the resident about turning the camera off every time they provided cares, and if the resident said no staff were instructed to tell the resident s/he would need to be moved to another room for cares to be performed. The resident told multiple staff s/he did not want to be constantly asked about the video camera.

The resident required extensive assistance from staff for all transfers and activities of daily living. The resident signed a notarized consent requesting a video camera be installed in his/her room. The consent indicated the resident did not want to discuss the video camera and requested staff to not pressure the resident into turning the camera off.

Staff were directed by administration every time they went into the resident's room to ask if they may turn the camera off while providing cares as the camera made staff uncomfortable. If the resident refused to have the camera turned off, staff were directed to inform the resident they would need to bring him/her into another room to provide cares. Review of the residents progress notes indicated multiple conversations staff had with the resident regarding the residents mental anguish related to staff treatment of the resident after the video camera was installed. The progress notes indicated the resident was tearful, felt staff treated him/her differently due to the video camera, and staff interaction had lessened due to the video camera.

When interviewed, the resident stated s/he installed the video camera in his/her room because of how the facility staff treated the resident, not providing cares including wound cares and incontinence cares, along with not providing cares timely. The resident did not want to be asked about the video camera by facility staff. S/he stated that staff started to treat him/her differently after the camera was installed, the resident felt like s/he was being ignored. The resident stated the video camera made him/her feel safe and s/he had made it clear to staff that s/he did not want to be asked about the camera every time staff came into his/her room. The resident stated that staff do not talk to him/her like they used to before the installation of the camera, and would ask about turning the camera off even before they were all the way in his/her room. The resident stated this treatment by the facility staff caused him/her to become emotionally upset.

When interviewed, 11 staff stated the resident told staff s/he did not want to discuss the video camera, however, staff were instructed by administration to ask the resident about the camera every time they provided cares. Staff stated they treated the resident differently after the video camera was installed by not going into the resident's room as much, not engaging in conversations with the resident, and by only focusing on providing care and then promptly leaving the resident's room. Staff felt they needed to watch what they were saying to the resident because of the camera.

Other allegations regarding the resident not being changed timely, skin care, a near fall, and ordering of a proper sling were reviewed. The resident had an individualized comprehensive assessment completed for toileting, turning and repositioning, and pressure ulcers. Interventions were developed and implemented by staff according to the assessment and according to the needs of the resident. Incontinence care was provided to the resident following the resident's care plan.

The residents medical record was reviewed for the last year and no near fall was documented from the sling. Staff were interviewed and facility incident reports were reviewed. There was no documentation regarding a near fall from the sling. Staff stated the sling used for transfers with the resident was a universal sling, and had been assessed as safe for the resident to use. The resident was interviewed and had no safety concerns regarding the mechanical lift and sling.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Neglect is not substantiated

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:

Administration instructed facility staff to ask the resident every time they went into the resident's room about turning the camera off, and instructed staff to tell the resident s/he would need to be moved to another room for cares to be performed if s/he refused to have the camera turned off. This treatment caused the resident emotional distress.

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 Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

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:

(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:

- [x] Medical Records
- [x] Care Guide

- [x] Medication Administration Records
- [x] Weight Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

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

Specify: _____

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: Three

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 12

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:

- [x] Personal Care
- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Use of Equipment
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Facility Tour
- [x] Incontinence

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

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

Were photographs taken: ◉ Yes ○ No Specify: Administration instruction for staff on video camer

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Bemidji Police Department

Bemidji City Attorney

Beltrami County Attorney