Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5012065M/ #H5012064C

Date Concluded: April 1, 2022

Name, Address, and County of Licensee Investigated:
Guardian Angels Health Center
400 Evans Avenue
Elk River, Minnesota
Sherburne County

Facility Type: Nursing Home

Evaluator's Name: Danyell Eccleston, 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), a staff member, physically abused the resident which caused the resident to have physical injuries to her forearm, forehead, and side of her face.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. Data gathered during the investigation indicated the AP was with the resident when she started crying out. The AP ignored the resident's continued cries after exiting her room, had the resident's DNA found on his clothing despite denying interacting with the resident during the time in question, fit the resident's description of her abuser, and was intoxicated during the incident. The AP also fit the description and was working during a previous evening when the resident expressed a staff member forcefully threw her down on her bed.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed employee training, facility policy and procedures, surveillance video, and the resident's medical record. In addition, law enforcement was contacted.

The residents medical record indicated diagnoses including Alzheimer's disease and dementia. The resident received assistance with medication management, supportive visits, behavior management, respiratory and vital sign monitoring, nail care, bathing, dressing assistance, grooming set-up, transfer assistance, cognitive function monitoring, falls prevention, toileting, and nutrition monitoring.

The video surveillance footage outside the resident's room in the hallway from the day of the incident was reviewed. The resident was observed sitting in a wheelchair in her doorway and the AP came up behind the resident and wheeled the resident back into her room. Seven seconds later, the resident started yelling out, and twenty-five seconds after that the AP walked out of the resident's room while the resident continuously yelled out. Approximately fifty-three seconds later, a staff member walked down to the resident's room while the resident wheeled herself forward to her doorway. The staff member called out to another staff member to come to the room and both staff members tended to the resident. The surveillance footage included audio of one of the staff member's asking the resident what happened and the resident stating that a man threw her to the ground.

The police report indicated the right side of the resident's face was red, she had a lump on the right side of her forehead with a dressing covering a possible laceration, and a laceration to the right forearm. The report indicated the resident's injuries did not appear consistent with someone who had fallen on the ground and the bump on her head did not appear from being hit by her nightstand or door. The report indicated that the officer noted areas of blood in the resident's room; blood on a sweater hanging on a rail near the door, blood on other clothing, blood on bed sheets, and blood near the bed on the floor. The report indicated the police officer noted blood on the AP's shirt and right pant leg, and later noted blood on the AP's left sock and both shoes. The report indicated after the police officer reviewed the scene and conducted interviews, he noted a smell of alcohol coming from the AP. Upon arriving to the jail, which was over eight hours from the start of the AP's shift at the facility, the AP provided a sample for a preliminary alcohol breath test to check for alcohol and the AP's sample came back with a 0.16 blood alcohol content.

A supplemental police report indicated DNA from suspected blood on clothing worn by the AP during the time of the incident matched DNA from the resident.

Review of photographs from the incident indicated the resident had injuries to her forehead, side of face, and forearm.

Correspondence with a forensic scientist at the Minnesota Bureau of Criminal Apprehension indicated preliminary breath tests approved for use by law enforcement have been evaluated and determined to be fit for purpose. Correspondence with the forensic scientist also indicated that it would be very unlikely that an average, healthy adult would have an alcohol concentration of 0.16 after consuming two beers and a shot of whiskey eight hours prior.

A facility incident report dated approximately five weeks prior to the incident indicated a person who wishes to remain anonymous told the nurse the resident appeared to be fearful of a male staff member when he was in the resident's room and the resident stated, "that man slammed me down so hard I think I broke my spine". The report indicated two male staff members worked the evening the resident appeared fearful and made the statement. Review of a staff schedule indicated the AP worked the evening the resident appeared fearful and made a statement about a male staff member slamming her down.

During interview, the AP denied using alcohol while working and stated during the day in question he consumed two beers and a shot of whiskey approximately an hour or two before his shift and denied being impaired at work. The AP stated it was not appropriate to use drugs before or during a shift and that he does not routinely take any medications. The AP stated during the day in question, he was assigned to care for the resident's roommate and denied providing any cares to the resident and believed he saw the resident that day when he passed her several times in the hallway. The AP stated his clothing became stained the evening of the incident and was not sure what the stains were from and stated if there was blood from the resident on his clothing, maybe there could have been blood on a divider curtain he interacted with when checking on the resident's roommate.

During interview, a nurse stated during the evening in question she heard the resident screaming from halfway down the hallway and went to the resident's room. The nurse stated the resident was in the doorway sitting in a wheelchair with a bloody face and a shirt in her hand that was full of blood. The nurse stated there was a blood trail from her bed to the door and when asked what happened, the resident stated a man threw her down and beat her. The resident gave a description of the man and the color of clothes he was wearing, which fit the description of the AP. The nurse stated the resident had an abrasion on her forehead and eyebrow.

During interview, an unlicensed personnel member stated at times the resident could get up on her own and stand if she was close to her bed or use a bathroom grab bar. The unlicensed personnel member stated she was assigned to the resident the evening of the incident and assisted the resident with evening cares and getting into bed. Later that evening, the unlicensed personnel member returned to assist the resident after she sustained injuries. The unlicensed personnel member stated blood was present on the resident's clothes and face and the resident stated a male pushed her to the floor.

During an interview, an individual who requested to be anonymous stated there was an evening when the resident appeared fearful of a male staff member [AP]. When the male staff member came into the room, the resident became very still, held her breath, and watched the male. The resident stated, “Do you know what that man did to me?” and then proceeded to share the male staff member slammed her down on her bed so hard that she thought she broke her spine.

In conclusion, abuse was substantiated. The AP was responsible for the maltreatment.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.
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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, resident deceased

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Internal facility investigation was conducted.
AP no longer working at facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
Elk River City Attorney
Elk River Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00611	A. BUILDING: _____ B. WING _____	C 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

(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 #H5012065M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H5012065M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. 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 non-therapeutic 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 non-therapeutic 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 period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		4/14/22

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure 1 of 1 residents (R1) reviewed was free from maltreatment. R1 was physically abused. Findings include: On April 1, 2022, the Minnesota Department of Health (MDH) issued a determination that physical abuse occurred, and that 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.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. Corrected 4/14/2022	