*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H5320070M

**Date Concluded:** April 1, 2022

**Name, Address, and County of Licensee Investigated:**
Woodlyn Heights
2060 Upper 55th Ave St. E
Inver Grove Heights, MN 55077
Dakota County

**Facility Type: Nursing Home**

**Evaluator's Name:** Carrie Euerle MSN, 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 applicable licensing standards for the provider type.

**Allegation(s):** Abuse occurred when a staff member/alleged perpetrator (AP) hit a resident leaving a bruise on the resident's jaw. Two staff members (AP1 and AP2) were identified as the alleged perpetrator.

**Investigative Findings and Conclusion:**
It was inconclusive whether abuse occurred. Although the resident sustained bruising to the face, there is not enough evidence to identify when or how the bruises occurred. There was conflicting information regarding the possible APs and no corroborating evidence was identified. As a result of this incident, federal deficiencies were issued related to abuse and reporting of maltreatment.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and the resident's family. Facility documents, internal investigation and policies and procedures were also reviewed.

The resident had diagnoses which included but not limited to dementia, anxiety, seizure disorder and left sided hemiplegia (paralysis of one side of the body). The resident required assistance of two staff and a mechanical lift for transfers and was dependent on staff for activities of daily living. The resident's care plan indicated the resident had impaired skin integrity and received medications which increased his/her risk for bleeding and bruising. In addition, the resident had a history of behaviors such as yelling out at staff, being physically and verbally abusive and resistive to cares. Facility assessments indicated the resident was susceptible to abuse due to impaired speech, mobility, and cognitive impairment.

Facility staff were informed of a bruise observed on the resident's left lower jaw. The resident was assessed by the nurse and another small bruise was observed on the resident's right lower jaw. The left side bruise measured 2.5 cm x 3 cm and the right-side bruise measured .75cm x .75 cm. The resident reported to staff that "an aide from the pool [agency staff] got angry and hit me." The resident could not recall what day or time this occurred, however the resident provided facility staff the name of the alleged perpetrator (AP1).

The name of AP1 provided by the resident was an employee of the facility, not of a staffing agency. The facility reviewed schedules from around the time the bruise was initially observed and noted there was an agency staff member who worked with the resident around this time (AP2). The facility immediately suspended AP1 and requested AP2 not return to the facility while they completed an internal investigation.

As part of the facility internal investigation, the administrator and director of nursing (DON) interviewed both AP1 and AP2 regarding the incident. AP1 indicated she had heard from another staff member that the resident had a bruise on her face and that an agency staff member had dropped her or hit her. During the facility interview, AP1 further stated the resident said something to AP1 like "you hit me yesterday." AP1 denied hitting the resident and indicated she was unaware of why the resident said that to her. AP2 denied abusing the resident and stated she never introduced herself to residents as an agency pool staff member.

Further facility investigation included showing the resident pictures of AP1 and AP2 to identify the correct AP. The resident identified AP1 as the staff member who hit her. The resident was shown the pictures of both AP1 and AP2 a second time and stated "this is the same person." The DON then explained to the resident that AP1 was a facility staff member and AP2 was a pool agency staff member, as the resident indicated it was a pool staff member who hit her.

The facility then interviewed additional residents who lived on the same wing as the resident and no concerns regarding abuse or mistreatment were reported. Additional staff interviewed could not provide further information regarding how the bruise occurred. There was no camera footage available to review.

Facility administration requested AP2 not return to the facility to work and AP1 was re-educated and returned to work at the facility. Following this incident, all staff were re-

educated on vulnerable adult maltreatment and reporting procedures. The bruises observed on the resident were assessed and monitored daily by facility staff until healed.

AP1 declined to be interviewed by the investigator.

AP2 was interviewed and denied abusing the resident.

The resident's family was interviewed and indicated they were aware of the incident and concerned of the treatment of the resident by staff at the facility. The family provided further examples of bruising of unknown origin observed on the resident during his/her stay at the facility.

Law enforcement initiated an investigation; the case was closed with no charges filed. The investigator assigned to the case indicated the resident had injuries consistent with abuse however, there was not enough evidence to identify and charge an AP.

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:
(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, no longer a resident of the facility
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility reported the bruise, contacted the resident's family and law enforcement, and began an internal investigation. AP1 was suspended and later re-educated, AP2 did not return to the facility and all staff were re-educated following the incident.

**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 http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm, 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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00829 | A. BUILDING: _____ B. WING _____ | C 04/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WOODLYN HEIGHTS HEALTHCARE CENTER** | **2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077** |

| (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<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5320070M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. | 2 000 | | |

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| 2 000 | Continued From page 1<br>The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents. | 2 000 | | |