Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HG403006M
Compliance #: HG403005C

Date Concluded: May 7, 2021

Name, Address, and County of Licensee Investigated:
REM River Bluffs Stone Park
3003 Stone Park Drive NE
Rochester, MN 55906
Olmsted County

Facility Type: Intermediate Care Facility (ICF)

Investigator's Name: Yolanda Dawson, RN

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 client was abused when he was found with injuries of unknow origin after morning cares by the alleged perpetrator (AP).

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP failed to assist the client or notify the nurse when the client was found with an abrasion on his eye and bleeding from his lip. It was inconclusive whether physical abuse occurred. The AP declined to be interviewed and ended his employment when questioned about the incident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the client's guardian. The investigator reviewed the client's record, staff schedules, personnel files and training records, policies, and procedures.

The client's diagnoses included autism, nonverbal, epilepsy, and anhidrosis. The client was admitted to the intermediate care facility with home care services for medication management, meal supervision, bathing, grooming, and dressing assistance, and behavior management.

Review of the client's IAPP indicated the client was unaware of potential hazards or dangers. He cannot distinguish between edible and inedible items. The client can be unsteady on his feet. Staff are to be aware of client's surroundings and stop him from walking into walls or falling into things. The client has a history of biting, pulling hair, pulling off eyeglasses, pinching other peoples' necks. He has done this when he is frustrated and when he is happy. The client does not have alone time at home or in the community.

During an interview, the nurse stated she has not witnessed and has not received a report of the client having seizures at all since his admission to the facility. The nurse stated that according to her last quarterly assessment the client was steady on his feet but did have a history of bumping into things. The nurse stated the client jumps up and down a lot during the day, however, there have been no reports of self-injury. The nurse stated there have been no reports of the client harming staff members.

During an interview, a staff member stated that after the AP provided morning cares and a shower to the client, he brought him to the kitchen table. The staff member stated she approached the client to give him his medications and breakfast and noticed that his face was bleeding. She asked the AP what happened to the client and why he was bleeding. The staff member stated the AP responded by saying he did not know what happened, he was not paying attention, and that he did not deal with blood so he did not clean it up, but that he saw it. The staff member asked the AP if he was going to tell her about it and the AP responded by saying he did not know what happened and "I didn't do anything, I don't know why you are trying to accuse me," and then he left because it was the end of his shift.

Review of the internal investigation indicated a staff member noticed the client was bleeding from the left side of his lip. The staff member responded to the client by getting a wet paper towel to clean the area and assessed what was happening. The staff member stated she found a small cut on the inner side of his left lower lip, along with some scratches on either side of his chin and a big scratch on the right side of his face, near his eye/temple of his forehead.

Review of an internal investigation indicated that after the AP assisted the client with morning cares, the client presented with scratches on his face and bleeding from his lip. The AP was placed on suspension following the incident. After the suspension, the only correspondence with the AP was through a voicemail he left for an Administrator. In the voicemail the AP stated he had no idea why he was being suspended. The AP stated that he did not do anything wrong, and that they did not have to suspend him, and that he was quitting.

In conclusion, neglect was substantiated.

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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, VA is nonverbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, did not respond to subpoena.

Action taken by facility:
Internal investigation conducted. Plan of action submitted. AP is no longer employed by the 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. 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 Mental Health and Developmental Disabilities
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01464	A. BUILDING: _____ B. WING _____	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM RIVER BLUFFS (STONE PARK)	3003 STONE PARK DRIVE ROCHESTER, MN 55904

(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
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. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG403006M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #HG403006M, tag identification 0700. NOTE: these results were not sent to provider	5 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. 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 number out of compliance are listed in the "Summary Statement of Deficiencies"	

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5 000	Continued From page 1 due to the provider closing on 03/21/2021 - mpm	5 000	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 investigators' 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 period of time, and only when necessary to protect the resident from self-injury or injury to others.	5 700		

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5 700	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interviews, and document review, unlicensed personnel (ULP) failed to ensure one of one client reviewed (C1) was free from maltreatment. C1 was neglected. The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on July 13, 2016, with diagnoses that included autism, nonverbal, epilepsy and anhidrosis. C1's ISSA dated July 7, 2020, indicated C1 received services from the intermediate care facility for medication management, meal supervision, bathing, grooming, and dressing assistance, and behavior management. Review of the client's IAPP indicated the client is unaware of potential hazards or dangers. He cannot distinguish between edible and inedible items. The client can be unsteady on his feet. Staff are to be aware of client's surroundings and stop him from walking into walls or falling into things. The client has a history of biting, pulling hair, pulling off eyeglasses, pinching other peoples' necks. He has done this when he is frustrated and when he is happy. The client does not have alone time at home or in the community. During an interview on May 5, 2021, at 5:27 p.m., a nurse stated she has not witnessed and has not received a report of C1 having seizures at all since his admission to the facility. The nurse stated that according to her last quarterly assessment in December, C1 was steady on his feet but did have a history of bumping into things.	5 700		

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5 700	Continued From page 3 The nurse stated C1 jumps up and down a lot during the day, however, there have been no reports of self-injury. The nurse stated there have been no reports of C1 harming staff members. During an interview on April 30, 2021, at 1:47 p.m., ULP-A stated that after the alleged perpetrator (AP) provided morning cares and a shower to C1, he brought him to the kitchen table. ULP-A stated she approached C1 to give him his medications and breakfast and noticed that his face was bleeding. ULP-A stated she asked the AP what happened to C1 and why he was bleeding. ULP-A stated the AP responded by saying he did not know what happened, he wasn't paying attention, and that he didn't deal with blood so that's why he didn't clean it up, but that he saw it. ULP-A asked the AP if he was going to tell her about it and the AP responded by saying I don't know what happened, I didn't do anything, I don't know why you are trying to accuse me, and then he left because it was the end of his shift. Review of the internal investigation dated November 27, 2021-December 2, 2021, indicated ULP-A noticed C1 was bleeding from the left side of his lip. ULP-A responded to C1 by getting a wet paper towel to clean the area and assessed what was happening. ULP-A stated she found a small cut on the inner side of his left lower lip, along with some scratches on either side of his chin and a big scratch on the right side of his face, near his eye/temple of his forehead. Review of the internal investigation dated November 27, 2021-December 2, 2021, indicated that after the AP assisted the client with morning cares, the client presented with scratches on his face and bleeding from his lip. The AP was placed on suspension following the incident. After	5 700		

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5 700	Continued From page 4 the suspension, the administrator (Admin-A) was unable to reach the AP. The only correspondence with the AP after the suspension was through a voicemail he left for Admin-A on 11/27/2020 at 12:29pm. In the voicemail the AP stated he had no idea why he was being suspended. The AP stated he did not do anything wrong, and they did not have to suspend him because he was quitting. Review of the AP's employee personnel & training records indicated the AP completed Vulnerable Adult/Maltreatment of Minors training on 7/22/2020. A document titled Job Description for Direct Support Professional undated, indicated the following: General Health Care: the Direct Support Professional (DSP) monitors individual's health; documents health concerns; communicates with nurse or supervisor as appropriate; calls 911 in the event of emergency; follows individual health care directives.	5 700		