Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20317001M
Compliance #: HL20317002C

Date Concluded: January 3, 2022

Name, Address, and County of Licensee Investigated:
Central Minnesota Senior Care
315 6th Street SW
Little Falls, MN 56345
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jeri Gilb, RN, MSN, CNP
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) neglected the resident(s) when the AP did not answer call lights, provide resident cares, administer requested pain medication, and acted erratically. The residents were fearful to be in the AP's care.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP was responsible for the maltreatment. After interviews and record reviews, a preponderance of evidence indicated the AP caused undue fear and discomfort for residents when she acted erratically and did not provide needed cares and medication administration.

The investigation included interviews with residents, facility staff members, including administrative, nursing, and unlicensed staff. In addition, the investigator reviewed residents' medical records, facility policies and procedures, incident reports, and employment and training records. The investigator contacted law enforcement and reviewed the police report.

Resident (R)1's medical record indicated diagnoses of uncontrolled diabetes mellitus (DM 2, chronic obstructive respiratory disease (COPD), weakness, and diabetic gastroparesis. R1 required staff assistance with meal preparation, medication management, oxygen management, hygiene reminders, housekeeping, and laundry services.

R2's medical record indicated diagnoses of cerebral palsy. R2 required staff assistance with medication management, hygiene and toileting assistance, meal preparation, housekeeping, and laundry services.

R3's medical record indicated diagnoses of COPD, bipolar disorder, morbid obesity, and chronic respiratory failure. R3 required staff assistance with medication management, meal preparation, mobility assistance, oxygen management, laundry, and housekeeping services.

R4's medical record indicated diagnoses of DM2, atrial fibrillation, and depression. R4 required staff assistance with medication management, meal preparation, hygiene and bathing assistance, housekeeping, and laundry services.

A police report indicated law enforcement was called to respond to the facility for suspicious activity. An employee had come to the facility and found some light-colored powder on the stove in the kitchen and another employee who worked overnight [AP] was still at the facility and acting "strangely." The officer arrived at the facility and noted a "finely ground crystal substance with light scratch marks on the stove top underneath it." The officer tested the substance for the presence of methamphetamine, and it tested positive. The AP was the only staff working the overnight shift from 11:00 p.m. to 7:00 a.m. Staff stated the AP was acting strange when they arrived at the facility that morning for their shift. The AP was looking for her keys, was wearing a residents clothing, and had a facility wound care kit in her personal vehicle. The officer located the AP in the back seat of her vehicle and described the AP as having great difficulty sitting still or maintaining eye contact, was talking very fast, and appeared to be very nervous and/ or agitated. When staff spoke to the residents some of the residents indicated they were greatly concerned and/ or fearful of the AP's behavior the previous evening, and other residents had not seen the AP at all. Several residents expressed concern with how the AP was dressed, so a resident borrowed the AP a blouse. Based on the officers' observations of the AP's erratic behavior and the presence of methamphetamine on the stove, the officer had the AP call someone for a ride and took the AP's keys to the police department for the AP to pick up at a later time. The police report indicated 3 days after the initial incident, the facility notified law enforcement they found a pill bottle in the medication administration room with the AP's name on and it contained a glass pipe and a small amount of marijuana.

When interviewed, R1 stated the night of the incident the AP slept and did not answer call lights. R1 stated he woke the AP up several times. When the AP did wake up she went to her car and still did not answer call lights. R 1 stated he followed the AP outside and told her the call lights were still going off and residents needed her assistance. R1 stated the AP acted wired and weird the rest of the night shift, "like she was on drugs or something." R1 stated he did not

sleep that night because the call lights kept him up and he worried about the other residents not getting help from the AP.

When interviewed, R2 stated the AP was very fidgety and moved quickly on the night shift of the incident. R2 stated the AP did not answer her call light for over 30 minutes. R2 stated the AP arrived at the facility dressed inappropriately in a tank top and very short shorts. R2 stated another resident had the AP wear her clothing because the AP's body was too exposed. R2 stated the AP was "out of it" and put her on the bed pan the wrong way, which resulted in urine spilling on her bed. The AP then put a towel over the spilled urine instead of changing the bed linen.

When interviewed, R3 stated the AP took an hour to answer her call light the night shift of the incident. The AP did not seem normal and appeared to be "on drugs"; "out of sorts" and jittery. R 3 required oxygen checks in the night due to respiratory conditions, but the AP neglected to check R3's oxygen. R3 stated she felt afraid because the AP did not appear capable of making safe decisions or taking care of any of the residents.
3 stated she felt afraid

When interviewed, R4 stated she activated her call light to ask for her nighttime pain medication the night of the incident. R4 stated it took over 30 minutes for the AP to answer her light. The AP said she would bring the medication back but never returned. R4 stated she did not sleep well that night due to discomfort and not receiving her requested pain medication.

When interviewed, facility staff stated the night/ early morning of the incident the AP paced in the facility, arms and hands flailing, fidgety, disheveled, wearing a resident's clothing over her own clothes. Facility staff stated the facility was in disarray, with papers and pillows scattered all over the floor. Facility staff stated there was a white powder with noticeable lines on the glass stovetop. Staff called law enforcement who tested the substance and determined the white powder on the stove to be methamphetamine.

Facility staff stated the AP did not return to the facility after this incident.

When interviewed, the AP stated she had a normal, quiet shift with nothing out of the ordinary. When questioned about reported erratic behavior, the AP stated her behavior was erratic because she lost her keys. The AP stated she wore a "schizo" resident's clothes because the resident told the AP to put them on. The AP stated she had on shorts because she spilled water on her pants. The AP stated she put a towel over a urine spot on the bed because the facility didn't train her properly. The AP denied sleeping or doing any illegal drugs on the job. The AP stated she didn't answer call lights for five minutes while she was outside smoking because she didn't hear them, but she could not recall which residents used their call lights that night. The AP reported she did check the oxygen on R3 but didn't document it because it was so hectic that night. The AP stated she didn't know how her narcotic prescription bottle with marijuana

and a pipe got into the facility because she doesn't do illegal drugs. The AP stated she has worked in assisted living facilities and group homes for 12 years.

Review of the facility training records indicated the AP completed training, including review of facility policies and procedures.

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.

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Not applicable, own guardians

Alleged Perpetrator interviewed: Yes

Action taken by facility: Alleged perpetrator is no longer employed 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
Little Falls Police Department
Little Falls County Attorney
Morrison County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20317	A. BUILDING: _____ B. WING _____	C 11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	320-632-2996 LITTLE FALLS, MN 56345

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an investigation. 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 November 3, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20317001M/ HL20317002C. At the time of the investigation, there were #8 clients receiving services under the assisted living license. The following correction orders are issued for #HL20317001M/ HL20317002C, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure four of four residents reviewed (R1, R2, R3, R4) were free from maltreatment. R1, R2, R3, and R4 were neglected. Findings include: On November 3, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	