State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL21152001M
Date Concluded: April 1, 2022
Compliance #: HL21152002C

Name, Address, and County of Licensee Investigated:
Serenity Living Solutions Sebeka
1005 Wells Avenue West
Sebeka, MN 56477
Wadena County

Facility Type: Assisted Living Facility (ALF)
Evaluator's Name: Jill Hagen, 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 facility staff, the alleged perpetrator (AP), abused the resident when during medication administration the AP held down the resident's arm, forced the medication into the resident's mouth, and plugged the resident's nose to make her swallow water and the medications.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP forced medications into the resident mouth, held down the resident's left arm, and plugged the resident nose to make her swallow water and medications against the residents will.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included a review of the resident's medical record, observations of medication administration, review of staff schedules, review of

staff training, the AP's personnel file, and facility's policies and procedures. In addition, the investigator contacted law enforcement.

The residents medical record indicated diagnoses including schizophrenia, Parkinson's disease, anxiety, and dementia. The resident made her basic needs known to staff and required assistance for decision making. The resident required staff assistance to complete all activities of daily living, including incontinence care, occasional assistance with eating due to tremors, used a wheelchair for mobility, and medication administration. The resident occasionally resisted taking medications and staff were directed to use alternative methods to administer the medications including crushing and concealing the medication in food and cutting the medications in half and re-approaching the resident in five minutes using a soft approach. The resident was identified as being at risk to be abused by others.

The facility incident report indicated one afternoon the resident refused to take her medications for a unlicensed personnel (ULP). The ULP requested assistance with the resident's medication administration from the AP. The AP and ULP entered the resident's room and shut the door. The AP used her fingers to put the medications in the resident's left cheek and the resident spit them out. At that time, the AP held down the resident's left arm on the chair and "shoved" the medications into the back of the resident's mouth, gave the resident a drink water, and pinched the resident's nose until she swallowed the medications. In response, the resident shook her head to avoid taking the medications.

The resident's medication administration record indicated the resident received three medications from staff at the time of the incident.

During interview, the registered nurse (RN) stated when she became aware of the incident, she assessed the resident. The resident had no signs of bruising or injury and had clear lung sounds. The resident had no memory of the incident. The RN stated the resident had the right to refuse the medication. The ULP that originally prepared the residents medications should have administered the medication, not the AP. Also, the resident should be given her medications on a spoon not by using your fingers and shoving them to the back of the resident's throat. If staff were unable to crush and conceal the medications, they should have notified the RN of the resident's refusal. All staff, including the AP, had been trained on the appropriate method to administer medications to the resident.

During interview, the ULP that witnessed the resident's medication administration by the AP stated, the resident refused to take the medication for the ULP that afternoon, so she requested assistance from the AP. The AP "grabbed" the medication cup from the ULP, went into the resident's room, and with her fingers put the medication "way back" in the resident's mouth, gave the resident water, and plugged the resident's nose to make her swallow. The AP held the resident's left arm on the chair to prevent her from grabbing the medication out of her mouth. The witness said the resident had no verbal response during the medication

administration by the AP. The ULP stated staff were directed to give the resident her medications on a spoon, if she refused a second time, staff were to contact the RN.

During interview, the AP stated she took the medication cup from the ULP to help administer the residents' medications. The AP stated she put the medication in the back of the resident's mouth, gave the resident water, and plugged the residents nose so she would swallow the medication. The AP said she "lightly" held down the resident's left arm when forcing the resident to take the medication. The AP was aware the resident took her medications on a spoon and had the right to refuse taking the medications. The AP stated instead of forcing the resident to take the medications she should have contacted the RN. The AP stated she was "burnt out" and knew it was wrong to administer medications to the resident against the resident's will.

The police investigation into the allegation remained open.

In conclusion, abuse was substantiated. The AP forced the medications into the resident's mouth, held down the resident's left arm, gave the resident water, and plugged the resident nose to force the resident to swallow the medication against her will.

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

Action taken by facility:
The AP is no longer employed at the facility. Management provided staff with verbal education regarding reporting of abuse and neglect.

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 Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Wadena County Attorney
Sebeka City Attorney
Sebeka Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21152	A. BUILDING: ____ B. WING ____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LVG SOLUTIONS SEBEKA	**1005 WELLS AVENUE WEST SEBEKA, MN 56477**

(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.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: #HL21152002C/HL21152001M On March 23, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were thirteen residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL21152002C/HL21152001M, tag identification 1620 and 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 assisted living facilities 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.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21152	A. BUILDING: ______ B. WING ______	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LVG SOLUTIONS SEBEKA	**1005 WELLS AVENUE WEST SEBEKA, MN 56477**

(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
01620	Continued From page 1	01620		

(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive re-assessment following a change in condition for one of one (R1) residents reviewed. Unlicensed personnel (ULP)-C placed medications in the back of R1's throat, held down R1's left arm, gave R1 water, and plugged R1's nose forcing R1 to swallow her medications.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21152	A. BUILDING: ______ B. WING ______	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LVG SOLUTIONS SEBEKA	**1005 WELLS AVENUE WEST SEBEKA, MN 56477**

(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
01620	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's Resident Profile with an intake date of March 13, 2019, indicated R1's diagnoses included schizophrenia, Parkinson's disease, dementia and anxiety. R1's vulnerability assessment dated March 8, 2022, indicated R1 was at risk to be abused by others. The assessment indicated R1's history included verbal outbursts and impatience. Staff were directed to leave R1 and return when R1 was calm, redirect R1, provide 24 hour supervision, observe for and remove R1 from potentially abusive/harmful situations and report any concerns to the housing manager or registered nurse (RN). R1's Service Plan with a review date of January 11, 2022, indicated R1 required assistance from staff to complete all activities of daily living, assistance to eat due to hand tremors, medication administration, incontinence care, and used a wheelchair for mobility. Review of the licensee's Internal Evaluation dated February 7, 2022, indicated unlicensed personnel (ULP)-B reported that on February 6, 2022, at 2:00 p.m. ULP-B was unable to get R1 to take her medications and requested assistance from ULP-C with the medication administration for R1. ULP-C entered R1's room and requested ULP-B close R1's door. ULP-C took the medications	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21152	A. BUILDING: ______ B. WING ______	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LVG SOLUTIONS SEBEKA	1005 WELLS AVENUE WEST SEBEKA, MN 56477

(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
01620	Continued From page 3	01620		

from ULP-B and proceeded to put the medications in R1's mouth. R1 spit out the medications so ULP-C held down R1's left arm on the chair and with her fingers ULP-C "shoved" the medications into the back of R1's mouth, gave R1 a drink of water and pinched R1's nose until R1 swallowed the medication. R1 did not cough or verbalize anything but shook her head to avoid taking the medications. The Internal Evaluation indicated ULP-B notified the licensed practical nurse (LPN) of the incident. The LPN "encouraged" ULP-B to notify the administrator of the incident. At 6:37 p.m. (four and one-half hours after the incident), ULP-B notified the administrator. The administrator failed to notify RN-A of the incident until the following day February 7, 2022, at 8:35 a.m.

R1's Master Care Plan dated of March 8, 2022, , indicated R1 occasionally was resistive to taking her prescribed medications. At those times, staff were directed to use alternative methods of administration of medications such as crushing and concealing the medication in food, halving the medication, or leaving R1 and re-approaching R1 in five minutes with a calm approach. Staff were directed to notify the RN with issues with R1's medication administration.

When interviewed on March 30, 2022, at 12:43 p.m. RN-A stated she was notified ULP-C forced R1 to take her medications the following morning after the incident. RN-A stated staff should immediately notify RN-A following the incident and an assessment should have been completed that afternoon. When assessed the following morning, R1 had no bruising or other observed injuries from the incident. Staff training for R1's medication administration included crushing or concealing the medications in food, cutting in

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21152	A. BUILDING: ___ B. WING ___	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LVG SOLUTIONS SEBEKA	**1005 WELLS AVENUE WEST SEBEKA, MN 56477**

(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
01620	Continued From page 4	01620		

halve or approaching R1 after five minutes. RN-A stated R1 had the right to refuse her medications and staff were educated to inform RN-A of R1's refusals. RN-A stated an assessment should have been completed following the incident with R1 to observe for any injuries or change in condition following the incident.

When interviewed on March 30, 2022, at 1:24 p.m., ULP-B stated she requested ULP-C's assistance administering R1's medications on February 6, 2022, around 2:00 p.m. ULP-C "grabbed" the medications from ULP-B, went into R1's room. ULP-C put the medications "way back" in R1's mouth. ULP-C held R1's left arm to prevent R1 from removing the medications. ULP-C gave R1 water and plugged R1's nose until she swallowed the medications. ULP-B did not immediately notify staff of the incident but left her shift around 3:00 p.m. and later contacted the LPN. ULP-B did not contact the RN about the incident.

When interviewed on March 30, 2022, 3:30 p.m., ULP-C stated she held down R1's left arm, put the medications in R1's mouth, gave R1 water and plugged her nose until R1's swallowed the medications.

Review of the licensee's policy and procedure titled Incident Report with a revision date of August 1, 2021, stated in the event of a change in condition or other injury an incident report must be completed. At the time of the incident, staff were responsible to notify the in-house or on-call RN.

Review of the licensee's policy and procedure titled Assessments, Reviews, and Monitoring with a revision date of August 1, 2021, stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21152	A. BUILDING: ______ B. WING ______	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LVG SOLUTIONS SEBEKA	**1005 WELLS AVENUE WEST SEBEKA, MN 56477**

(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
01620	Continued From page 5 nursing reassessment must include all the elements of the uniform assessment tool as required and conducted in person, dated, and signed by the RN who conducted the assessment. On-going resident reassessment and monitoring must be conducted as needed based on changes in resident needs. TIME PERIOD FOR CORRECTION: Seven (7) days.	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On March 23, 2022 , the Minnesota Department of Health (MDH) issued a determination that 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	