Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL239868285M
Compliance #: HL239865464C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:
Elderwood of Hinckley
710 Spring Lane,
Hinckley, MN, 55037
Pine County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff member, abused a resident when the AP argued and fought with the resident leaving a bruise on the resident's arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the resident was found with a bruise, there was not a preponderance of evidence the AP abused the resident. The AP immediately removed himself from the situation and requested another staff member care for the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the AP and the resident. The investigation included review of the resident's medical record, facility investigation, photo of the AP, and policies and procedures. Also, the investigator observed the facility, resident's room, and common areas.

The resident resided in an assisted living memory care unit. The resident's diagnoses included paranoid schizophrenia. The resident's service plan included assistance with meals and snacks as needed and safety checks every two-hours. The resident's assessment indicated the resident was alert, and oriented, had delusions and mistrusted other people. The resident's individual abuse prevention plan indicated the resident had paranoid behaviors and angry outburst towards other people.

The facility investigation indicated one night the AP brought the resident toast with jelly on a plate. The resident stated the AP pulled the plate away from her and the plate and toast fell on the floor. The resident stated her, and the AP started hitting each other. The resident complained of right shoulder pain but refused an x-ray at a doctor's appointment.

The facility investigation included an interview with the AP. The AP reported he brought the resident a glass of water and toast and the resident told the AP to get out of her room. The resident called the AP a derogatory term and threw the toast at the AP. The AP walked out of the resident's room and asked a co-worker to assist the resident for the remainder of the night.

During an interview, the resident initially stated no staff had yelled or hit her. Later, the resident stated the AP brought her toast and her and the AP started to fight. The AP scratched the inside of her right arm. The resident showed facility staff her arm however, no scratches were observed.

During an interview, the nurse stated the resident reported she was sitting in her recliner when the AP came into her room and threw toast at her. The resident reported the AP started to fight with her causing a bruise on her right forearm. The nurse stated the bruise looked old and faded.

During an interview, the AP stated the resident asked for toast with jelly and a glass of water. When the AP returned with toast and a glass of water, the resident called the AP a derogatory term and that he was the "slowest servant." The resident picked up the toast and threw it at the AP, hitting him. The AP denied fighting or hitting the resident. The AP stated he walked out of the resident's room and went to the bathroom to clean up because he had jelly on his clothes. The AP stated he requested the other unlicensed staff member assist the resident for the remainder of the shift.

During an interview, the unlicensed staff member stated the AP brought toast to the resident, came out of the resident's room, and the AP reported the resident picked the toast off the plate and threw it at him. The unlicensed staff member stated the AP reported the resident told the AP to get out of her room and not come back. The unlicensed staff member stated the AP was covered in jelly and went to the bathroom to clean himself up. The unlicensed staff member stated the resident called for help about 30 minutes later and when in the resident's room, the resident called the AP a derogatory term and told the unlicensed staff member to clean the

carpet like a “good servant.” The unlicensed staff member stated the resident did not mention the AP hit or fought with the resident. The unlicensed staff member stated the resident did not have a bruise, marks, redness, or scratches on her arms.

During an interview, leadership stated the resident had delusions and hallucinations at times. When the allegation came out, the AP was suspended from work. The resident did not want to see a doctor after the incident. Leadership stated the resident’s medications had been adjusted and the resident continued to have angry outbursts.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Resident was own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Upon learning of the allegation, the facility suspended the AP immediately. The facility implemented two staff when entering the resident’s room and offered the resident to be seen by a doctor. The facility completed an internal investigation.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	23986	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(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 On September 20, 2023, the Minnesota Department of Health initiated an investigation of complaint HL239867524M/ HL239864075C and HL239868285M/HL239865464C . No correction orders are issued.	0 000		