Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL24964003M **Date Concluded:** October 11, 2021

Name, Address, and County of Licensee Investigated:
Nurturing Care Residence
4441 Hunters Ridge Road
Minnetonka, MN 55345
Hennepin County

Facility Type: Home Care Provider **Evaluator's Name:** Lori Pokela, RN
Rapid Response

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) physically abused the resident when the AP pushed the resident twice while guarding food. The resident continued to stand next to the AP. The resident then pushed the AP. The AP pushed the resident one more time and the resident fell and sustained two small lacerations on the top of the resident's left hand.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP pushed the resident several times, contributing to the resident falling and sustaining two small lacerations on the left hand.

The investigation included interviews with facility staff members and family of the resident. Facility video footage of the incident was observed. The resident's medical record, including an internal investigation of the incident was reviewed. Facility policies and staff training records were reviewed.

The resident's diagnoses included frontal lobe dementia, Traumatic Brain Injury (TBI), and depression. The service plan included staff assistance of one to two staff members for activities of daily living, such as dressing, grooming, bathing, and toileting. The progress notes indicated the resident is contracted with a hospice agency due to progression of the resident's dementia.

The resident's Individual Assessment Prevention Plan (IAPP), indicated the resident was hard of hearing, had slow thinking process, and speech ranged from clear to incoherent. This same document indicated the resident may wander into kitchen when hungry and eating needs were an area of vulnerability.

Review of an incident report indicated the registered nurse (RN) received a text from the AP to report the resident had an injury to a hand and a bumped head. The AP also reported the resident was reaching out for the AP's food while the AP was eating, and the resident tried to hit the AP when the AP stated "no." The AP then stood up to block the resident's fist and the resident fell backward and injured a hand and the resident's head. The AP also reported wrapping the resident's hand and did not notice any bruising on the resident's head. The incident report indicated the nurse arrived at the facility in an hour and assessed the resident including treatment to two small lacerations on the top of the resident's left hand.

The resident's Medication Administration Record (MAR) indicated the resident received the scheduled dosage of antianxiety and antipsychotic medications on time. No documentation indicated an as-needed dose of antianxiety was administered on the date of the incident.

Facility video footage dated for the day of the incident was reviewed during this investigation. This footage showed the resident standing at the nursing station behind the AP, with the AP holding her right arm out while seated at the desk. While the resident continued standing behind the AP, the AP pushed the resident back with her extended right arm several times until the resident grabbed the AP's right wrist, then the AP pushed the resident, and the resident fell backward. The AP attempted to sit the resident up but did not assist the resident off of the floor. The resident then stood up independently and looked down at his left hand. The AP was seated at the nursing station when the resident stood up per self. The resident approached the AP who had an extended right arm to keep the resident away from the desk. The resident then walked away from the desk looking at his left hand, which had two visible injuries to the skin.

During interview, the nurse stated that in the text she received from the AP after the incident, the AP said the resident had lost balance. The nurse stated although the resident had a history of wandering, balance was never previously an issue. The nurse stated after reviewing the facility camera footage, it was clear that the resident never grabbed the AP's food, the AP had pushed the resident several times until the resident fell and sustained injuries. The nurse stated staff are trained on appropriate behavior interventions to utilize if the resident becomes aggressive, such as the reapproach method. The nurse also stated the resident will "hover" around per baseline, especially when hungry, which is why the resident is to be offered "on-

the-go" foods whenever possible. The nurse stated the AP was no longer is employed by the facility after this incident.

In conclusion, abuse 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.

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. Frontal lobe dementia and cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP was contacted at two listed phone numbers with no return call.

Action taken by facility:
The facility conducted an internal investigation of the incident. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
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
Hennepin County Attorney
Minnetonka City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H24964	A. BUILDING: _____ B. WING _____	C 10/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURTURING CARE RESIDENCE	4441 HUNTERS RIDGE RD PLYMOUTH, MN 55446

(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 The Minnesota Department of Health conducted a maltreatment investigation, in accordance with Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minnesota Statute § 626.557. The Minnesota Department of Health issued a correction order pursuant to the investigation. INITIAL COMMENTS: On September 7, 2021, the Minnesota Department of Health conducted a maltreatment investigation of complaint #HL24964003M. The following correction order is issued for #HL24964003M, tag identification 0325.	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. 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" 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 is 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.	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors 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 resident reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On October 10, 2021, 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.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	