

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL254606324M
Compliance #: HL254602024C

Date Concluded: June 16, 2023

Name, Address, and County of Licensee

Investigated:

Cypress Manor
16770 Wren Street NW
Andover, Minnesota 55304
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Inconclusive

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) abused the resident when the AP put a soiled wipe up to his face and then pushed him during a transfer.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. The resident could not recall the incident; only the AP and one other staff member were able to provide firsthand knowledge of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident's medical record. Also, the investigator observed incontinence care, transfers, and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included brain damage. The resident's service plan included assistance with incontinence care and transferring. The resident's assessment indicated the resident received full assistance for incontinence. Additionally, this assessment indicated the resident used a wheelchair but did walk short distances with staff.

An incident report indicated the AP swore at the resident and told him to shut up. While cleaning the resident after having a bowel movement, the AP placed a soiled wipe in front of the resident's face. Additionally, the AP shoved the resident, causing him to fall onto his bed.

During an interview, an ULP stated the AP seemed to be in a rush to help her change the resident's soiled brief and did not want to be in the room longer than needed. The AP placed a soiled wipe up to the resident's face to show him they were still cleaning him up. Additionally, while helping transfer the resident, the AP pushed the resident onto the bed.

During an interview, the resident could not recall the events of the incident. The resident stated he felt safe at the facility and had no concerns with how staff treated him.

During an interview, the AP denied swearing at the resident. The AP also denied placing a soiled wipe up to the resident's face, as well as shoving the resident during a transfer to the bed.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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; unable to contact.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an investigation. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. 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>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/31/2023
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NAME OF PROVIDER OR SUPPLIER CYPRESS MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 16770 WREN STREET NW ANDOVER, MN 55304
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL254602024C/#HL254606324M and #HL254602720C</p> <p>On May 31, 2023, 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 10 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL254602024C/#HL254606324M, tag identification 0620 and 3000.</p> <p>The following correction order is issued for #HL254602720C, tag identification 0590.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 590 SS=F	<p>144G.42 Subd. 3 Facility restrictions</p> <p>(a) This subdivision does not apply to licensees</p>	0 590		

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

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0 590	<p>Continued From page 1</p> <p>that are Minnesota counties or other units of government.</p> <p>(b) A facility or staff person may not:</p> <p>(1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or</p> <p>(2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person.</p> <p>(c) A facility may not serve as a resident's legal, designated, or other representative.</p> <p>(d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee allowed a staff member, owner (OW)-F, to serve as power of attorney (POA) for two of two residents (R2, R3).</p> <p>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 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2 admitted to the licensee August 8, 2022. R2's diagnoses included chronic kidney disease. R2's face sheet identified OW-F as his POA.</p>	0 590		
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0 590	<p>Continued From page 2</p> <p>A Statutory Short Form Power of Attorney dated August 16, 2022, identified OW-F and a family member as R2's POAs.</p> <p>R3 admitted to the licensee September 23, 2022. R3's diagnoses included severe cognitive impairment. R3's face sheet identified OW-F as her POA.</p> <p>A Statutory Short Form Power of Attorney, dated August 16, 2022, identified OW-F and a family member as R3's POAs.</p> <p>During email correspondence on May 31, 2023, at 8:25 a.m., anonymous-G identified OW-F as R2's and R3's POA</p> <p>During an interview on June 5, 2023 at 2:39 p.m., anonymous-H identified OW-F as R2's and R3's POA.</p> <p>The licensee-provided policy titled Facility Restrictions dated June 6, 2022, indicated staff would were not allowed to accept a power-of-attorney from residents for any purpose.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	0 590		
0 620 SS=D	<p>144G.42 Subd. 6 (a) Compliance with requirements for reporting ma</p> <p>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all</p>	0 620		

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0 620	<p>Continued From page 3</p> <p>cases of suspected maltreatment are reported.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment of a vulnerable adult immediately, no longer than 24 hours, for an incident involving a resident (R1).</p> <p>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 resident's health or safety) 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).</p> <p>The findings include:</p> <p>R1 admitted to the licensee December 23, 2015. R1's diagnoses included anoxic brain damage. R1's service plan dated December 23, 2022, indicated R1 received services including incontinence care and transfer assistance.</p> <p>An incident report dated April 19, 2023, indicated a staff member held a soiled wipe in front of R1's face, shoved him during a transfer, and swore at him.</p> <p>The licensee reported this incident to the Minnesota Adult Abuse Reporting Center (MAARC) on April 21, 2023.</p> <p>During an interview on May 31, 2023 at 1:42 p.m., assisted living director in residency (ALDIR)-A stated an incident should be reported within 24 hours.</p>	0 620		

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0 620	Continued From page 4 The licensee-provided policy Vulnerable Adult Maltreatment - Prevention & Reporting dated March 31, 2023, indicated a report would be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	03000		

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03000	<p>Continued From page 5</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment of a vulnerable adult immediately, no longer than 24 hours, for an incident involving a resident (R1).</p> <p>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 resident's health or safety) 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).</p> <p>The findings include:</p>	03000		

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03000	<p>Continued From page 6</p> <p>R1 admitted to the licensee December 23, 2015. R1's diagnoses included anoxic brain damage. R1's service plan dated December 23, 2022, indicated R1 received services including incontinence care and transfer assistance.</p> <p>An incident report dated April 19, 2023, indicated a staff member held a soiled wipe in front of R1's face, shoved him during a transfer, and swore at him.</p> <p>The licensee reported this incident to the Minnesota Adult Abuse Reporting Center (MAARC) on April 21, 2023.</p> <p>During an interview on May 31, 2023 at 1:42 p.m., assisted living director in residency (ALDIR)-A stated an incident should be reported within 24 hours.</p> <p>The licensee-provided policy Vulnerable Adult Maltreatment - Prevention & Reporting dated March 31, 2023, indicated a report would be made no later than 24 hours after the maltreatment was first suspected.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	03000		