Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282095603M
Compliance #: HL282099599C

Date Concluded: August 16, 2023

Name, Address, and County of Licensee Investigated:
Birchview Gardens Assisted Living
108 3rd Street North
Hackensack, MN 56542
Cass County

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

Evaluator's Name: Barbara Axness, 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 facility emotionally abused the resident when it retaliated against a resident who made a complaint about meal service. The resident experienced emotional distress after facility staff told him he could no longer eat in the dining room and had to eat meals in his room after he raised concerns about the temperature of food.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident and facility staff denied the incident occurred. The resident stated he was able to choose where he eats, didn't feel like he was restricted to eating in his room, and felt comfortable voicing concerns to staff without retaliation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical

records including assessments, progress notes, and the service plan. Also, the investigator observed meal service at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included hypertension (high blood pressure), weakness, and depression. The resident's service plan included assistance with dressing, grooming, toileting, and medication administration. The resident's assessment indicated the resident had short term memory loss and would eat meals in the dining room or in his room. The resident was able to self-propel in his wheelchair.

During investigative interviews, facility staff could not recall an event where the resident was told he would have to eat in his room and/or not allowed to eat in the dining room. Facility staff stated the resident normally ate breakfast in the dining room and ate his other meals in his apartment. Facility staff stated the resident had not voiced any concerns about his meal service and if he wanted to eat all meals in the dining room, they would honor that request.

During investigative interviews with other residents at the facility, the residents indicated they were able to decide where they ate their meals and felt comfortable bringing concerns forward to facility management.

The resident was interviewed and could not recall if the event occurred. The resident had no concerns with his care and felt comfortable voicing concerns to staff. The resident stated he ate in his room sometimes and that was his preference.

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: Not Applicable
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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
	28209	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIVING	108 3RD STREET NORTH HACKENSACK, MN 56452

(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 August 14, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL282095603M, HL282099599C. No correction orders are issued.	0 000	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. 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. 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.	