

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL301084963M
Compliance #: HL301088516C

Date Concluded: August 2, 2023

Name, Address, and County of Licensee

Investigated:

Water's Edge
800 Agency Trail
Mankato, MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Inconclusive**

Nature of the 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) emotionally abused a resident when they held the incontinence brief in the resident's face and told her it was not dirty or leaking.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. While the AP did provide cares to the resident, the AP denied inappropriate behavior and there were no other witnesses.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the AP's personnel record, facility's policies, and procedures. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living unit. The resident's diagnoses include Crohn's disease of small intestine and colostomy. The resident's assessment indicated she had a urostomy (a surgically placed opening for emptying urine placed on the abdomen). The resident's service plan included assistance to change ostomy bag(s).

One night, the resident asked the AP staff to change her ostomy bag(s) due to leaking. When the AP came to assist the resident she held the resident's brief in the resident's face, telling her it was not dirty and said her ostomy bag(s) were not leaking. While the AP did provide her cares, she resident felt embarrassed and ashamed.

During an interview, the resident stated she asked AP to change the bag for her because it was leaking, but the AP was not willing to do so. The AP told her the bag was not leaking and she did not need to be changed. Despite the resident's insistence that she needed to be changed, AP took her brief off and held it in front of her face to show her the brief was dry. The resident described feeling humiliated and ashamed by this incident. She promptly reported the incident to the nurse and management staff.

During an interview, a family member stated she had heard the story from the resident. Subsequently, she approached the administrator to request AP not be allowed to work with the resident again. The administrator assured her that they had initiated an investigation into the matter and as a result, the AP would no longer be permitted to work with the resident.

During an interview, the AP stated she had worked during that weekend. According to her recollection, she provided the resident with her pain medication and changed the bags as requested, with nothing else out of the ordinary happening. However, a day later, the management contacted her to investigate concerns with the cares provided the resident. The AP stated she was confused why the resident made such a claim. The AP stated she is no longer employed at the facility.

During an interview, the nurse stated the management staff received an email from a family member regarding the incident, which led to an internal investigation. The nurse stated the AP was suspended during the investigation. The resident was assessed for injuries, and none was noted. Subsequently, they conducted interviews with both the resident and AP. The AP neither denied nor admitted the behavior. The nurse stated the resident is no longer employed by the facility. The nurse stated there were no witnesses to the events described by the resident and upon assessment at the time there were no injuries identified.

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; Stop here if it is not a restraints issue or sexual abuse.

(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 management decided to suspend AP pending further investigation. The resident was assessed for injuries. They conducted interviews with both the resident and AP. In response to the situation, the management took further measures to ensure the safety and well-being of other residents. They began conducting interviews with other residents to ascertain whether they had experienced any similar behavior from the AP.

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.

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/20/2023 |
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| NAME OF PROVIDER OR SUPPLIER WATER'S EDGE | STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001 |
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| (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 | <p>Initial Comments</p> <p>On July 20, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL301084963M/HL301088516C. No correction orders are issued.</p> | 0 000 | | |

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