Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303996043M
Compliance #: HL303991205C

Date Concluded: December 22, 2023

Name, Address, and County of Licensee Investigated:
Vista Prairie at Goldfinch Estates
850 Goldfinch Street
Fairmont, MN 56031
Martin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Substantiated, individual responsibility**

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) abused the resident when she gave the resident a cold shower, prompting her to react vocally, and she recorded the resident's reaction on Snapchat.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP gave the resident a shower which included exposure to cold water and recorded the resident on Snapchat (a social media platform).

The investigator conducted interviews with facility staff members, including administrative 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, incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include intellectual disabilities and depression. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The service plan also included the resident preferred warm showers.

The facility internal investigation documents indicated a staff member reported the AP played a Snapchat audio recording. The same documents indicated the staff member said the resident could be heard in the recording screaming "Stop that, [AP's name]". The AP told the staff member she turned the water to cold and gave the resident a cold shower.

The facility internal investigation documents included notes from an interview with the AP. These notes indicated the AP admitted to recording the AP during the cold shower and the resident told her to stop. The AP stated she thought it was a joke to do this with the resident. The AP claimed she was turning the water off when it transitioned from warm to cold and acknowledged she recorded the resident on social media.

During an interview, the staff member stated the AP told her she had a recording of the resident screaming when she turned the warm water to cold water temperature during her shower. The staff member stated the AP found it amusing and recorded the resident and that the AP laughed about it while relating the story. The staff member stated later the resident was terrified to receive a shower because of what had happened.

During an interview, a management staff stated a staff member reported to her the AP gave a cold shower to a resident and recorded audio of the incident on Snapchat. She stated she spoke to the AP, who admitted to recording the audio while giving the resident a cold shower. Following the investigation, the AP resigned and declined further discussion with the management team.

During the investigation, the attempts to interview the AP were unsuccessful.

In conclusion, the Minnesota Department of Health determined 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.

Physical Abuse: Minnesota Statutes, section 260E.03, Subd. 18
"Physical abuse" means any physical injury, mental injury under subdivision 13, or threatened injury under subdivision 23, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

(b) Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian that does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582.
(c) For the purposes of this subdivision, actions that are not reasonable and moderate include, but are not limited to, any of the following:
(1) throwing, kicking, burning, biting, or cutting a child;
(2) striking a child with a closed fist;
(3) shaking a child under age three;
(4) striking or other actions that result in any nonaccidental injury to a child under 18 months of age;
(5) unreasonable interference with a child's breathing;
(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
(7) striking a child under age one on the face or head;
(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;
(9) purposely giving a child:
(i) poison, alcohol, or dangerous, harmful, or controlled substances that were not prescribed for the child by a practitioner in order to control or punish the child; or
(ii) other substances that substantially affect the child's behavior, motor coordination, or judgment; that result in sickness or internal injury; or that subject the child to medical procedures that would be unnecessary if the child were not exposed to the substances.
(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining.

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: No, attempts to interview unsuccessful
Alleged Perpetrator interviewed: No, attempts to interview unsuccessful

Action taken by facility:
The facility initiated an internal investigation, suspended the AP, and updated the resident’s service plan. The AP resigned.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Martin County Attorney
Fairmont City Attorney
Fairmont Police Department
Minnesota Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30399	A. BUILDING: _____ B. WING _____	C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GOLDFINCH ESTATES	850 GOLDFINCH STREET FAIRMONT, MN 56031

(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 November 14, 2023, the Minnesota Department of Health initiated an investigation of complaint HL303996043M/HL303991205C. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	