Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304316562M
Compliance #: HL304319802C

Date Concluded: December 23, 2024

Name, Address, and County of Licensee Investigated:
Pierz Meadow Ponds Inc
305 Ronald Avenue
Pierz, MN, 56364
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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), a contracted staff member, abused the resident when the AP choked the resident to the point where the resident saw "stars" and the resident almost passed out. The resident feared for his life.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting reports of the incident between the resident and the AP. The AP denied the allegations, there was no physical evidence of injury to the resident, and no witnesses to the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the AP. The investigation included review of the resident record, facility internal investigation, facility incident report, personnel file, staff schedules, related facility

policy and procedures. Also, the investigator observed the resident, staff interactions with the resident, and staff interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included emphysema (long term lung condition.) The resident's service plan included assistance with monitoring oxygen saturations (percent of oxygen in the blood) three times daily. The resident was independent with dressing, grooming, transfers, and toileting. The resident required assistance from staff to transport his oxygen when walking outside his room. The resident slept on his couch or in a recliner, normally slept from 11:00 p.m. to 7:00 a.m., and did not sleep well fearing people would come into his room. Staff monitored the resident's oxygen saturation with a probe used with an oximeter (non-invasive medical device) placed on the resident's finger, every shift due to the resident's oxygen use. The resident was oriented, had memory problems with mild confusion, and was disoriented to time.

Records indicated the resident reported that one day, during the overnight shift, the AP came into his room and shook the resident violently until he woke up. The AP put her hands around the resident's neck, choked him to the point he "saw stars", and the resident almost passed out. The resident said he did not call someone after the incident occurred because the AP was the only staff working. The resident also stated he did not call 911 because he did not think of doing that and did not know he could. The resident asked daytime staff members if he had any marks on his neck. Both staff reported there was no visible marks on the resident's neck.

Records indicated the AP reported the resident refused to allow the AP to take the residents oxygen saturation and assaulted the AP with his walker. The AP explained to the resident that the AP was checking the oxygen saturations because the resident had been congested and not feeling the best. The AP left the resident's room after the resident asked the AP to leave.

Scheduled services record indicated the resident had oxygen saturation checks scheduled on the overnight shift.

During an interview, the AP stated she went into the resident's room to take the resident's oxygen saturations. When the AP attempted to place the probe on the resident's finger to measure the oxygen saturation, the resident got up off couch, grabbed his walker, pushed the walker against the AP, and told the AP to get out of his room. The AP denied choking the resident. The AP said she had worked with the resident prior to this shift and checked his oxygen saturations without issue.

During an interview, a nurse stated she checked the resident's neck for injury. The nurse stated the resident did not have redness, bruising, or any marks on his neck.

During an interview, leadership stated there were conflicting accounts from the resident and the AP as to what occurred. Camera footage showed the AP enter the resident's room and leave. There were no witnesses to the incident. Leadership stated he viewed images of the

resident’s neck which were taken from the front, right, left, and back side. There were no areas of redness, fingerprints, or marks of any kind. Leadership stated the AP had worked with the resident prior and no concerns were brought up from their previous interaction.

During an interview, the resident stated he was asleep on the couch, when AP shook the resident to wake him, and choked the resident to the point where he had “saw stars.” The resident said he did not know who the AP was, had not seen the AP before, and had not seen the AP since.

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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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 facility conducted an internal investigation. The resident's service times were changed for staff to monitor the resident's oxygen saturations only during awake hours. The AP is no longer a contracted staff at the facility.

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
	30431	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

(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 December 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL304319802C/#HL304316562M. No correction orders are issued.	0 000		