Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30498001M
Compliance #: HL30498002C

Date Concluded: January 10, 2022

Name, Address, and County of Licensee Investigated:
Vermilion Senior Living
1232 Birch Street North
Tower, MN 55790
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged the resident was physically and verbally abused when the alleged perpetrator (AP) squeezed, pulled, and shoved, and punch the resident's genitals against the edge of a toilet riser causing the resident to scream in pain and then yelled at the resident.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and AP were responsible for the maltreatment. Facility staff witnessed the AP physically abuse R1 then yelled at the resident. When interviewed, several other facility staff had also witnessed the AP repeatedly verbally abuse the resident by yelling at him in an aggressive manner. The facility staff did not intervene to ensure the AP did not continue to abuse the resident.

The investigation included interviews with facility staff including administrative, nursing, and unlicensed staff. The residents medical record, employee records, incident reports, staff

education, and facility policy and procedures were reviewed. Observations were made of the facility environment and staff and resident interaction.

The residents medical record indicated the resident was admitted to the facility with diagnoses including Alzheimer's Disease, Dementia, Chronic Pain Syndrome, and was receiving hospice services. The resident was cognitively impaired and required assistance with dressing, grooming, toileting, and transfer assistance.

The residents "Individual Abuse Prevention Plan" indicated he was at risk for being abused and was not able to report abuse or identify if he was in an unsafe situation. The plan directed staff to monitor and remove the resident from any abuse.

A facility incident report indicated the administrator was notified a staff member observed the AP being verbally and physically aggressive with the resident.

An employee discipline report indicated the day of the incident the AP was observed to be physically aggressive with the resident while assisting the resident to use the toilet. Staff reported they observed the AP aggressively squeeze and shove the resident's male genitalia into a toilet riser causing the resident to scream out in pain. The AP began yelling at the resident "shut up, there is nothing wrong with you" in an aggressive manner. The report indicated the staff member told the AP she would take over the resident's care. The report indicated the AP's employment ended because of her conduct.

The resident's Service Delivery of Care Record indicated the AP continued to provide services for the resident and worked the remainder of the scheduled shift following the reported allegation of physical and verbal abuse. In addition, the record indicated the AP worked the following day, and continued providing services and care for the resident.

When interviewed facility staff reported witnessing the AP repeatedly verbally abuse the resident prior to the allegation of physical and verbal abuse reported to the facility. Facility staff stated the AP yelled in an aggressive threatening manner by leaning into the resident's face and yelling at him on several occasions prior to the allegation of physical and verbal abuse reported to the facility. One staff indicated they had reported their concern of the AP's verbally abusive behavior to administration. Another staff stated they had not reported their concerns of the AP's verbal abusive conduct toward the resident prior to the incident.

The facility incident reports were reviewed and there were no other documented and/ or investigation reports from staff of the AP's ongoing abusive behavior.

The investigator made attempts to contact the AP including sending a subpoena. The AP did not respond to requests.

In conclusion, abuse was substantiated. The facility and AP were responsible when they did not report concerns of the AP's verbally abusive behavior towards the resident. As a result, the resident experienced ongoing abuse from the AP. The facility failed to protect the resident and other vulnerable adults by allowing the AP to continue working following allegations of abuse against the AP were reported.

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;
(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: Attempted, unable to be interviewed.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No response to attempts to interview.

Action taken by facility:
The AP is no longer employed by 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

St. Louis County Attorney
Tower City Attorney
Tower City Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30498	A. BUILDING: _____ B. WING _____	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILION SENIOR LIVING	1232 BIRCH STREET NORTH TOWER, MN 55790

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. On December 14, 2021, the Minnesota Department of Health conducted a complaint investigation HL30498001M, and HL30498002C at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 14 residents receiving services under the provider's Assisted Living license. The following correction orders were issued for HL30498001M, and HL30498002C, tag identification 0620, 1500, 2360, 3000, and 3030.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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 cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to immediately report an allegation of abuse to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident, R1, reviewed with allegations of abuse. 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 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). Findings include: R1 was admitted to the facility on May 18, 2021, with diagnoses including Alzheimer's Disease, Dementia, and Chronic Pain Syndrome. R1's service agreement dated August 31, 2021, indicated the resident utilized hospice services and required assistance with dressing, grooming, toileting, and mobility. R1's Individual Abuse Prevention Plan dated May	0 620		

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0 620	Continued From page 2 18, 2021, indicated the resident was at risk for being abused and would not be able to report abuse or identify if he was in a unsafe situation. The plan directed staff to monitor and remove the resident from any abuse. An incident report dated September 21, 2021, at 6:00 p.m. indicated the administrator documented facility staff had reported witnessing another staff being verbally and physically aggressive with the resident. An employee discipline report dated September 21, 2021, indicated the day of the incident unlicensed personnel (ULP)-B witnessed ULP-A being physically aggressive with R1 while assisting him to use the toilet. ULP-B reported she observed ULP-A squeeze, shove, and punch the resident's male genitalia into a toilet riser causing the resident to scream out in pain. When R1 yelled ULP-A yelled at the resident in an aggressive manner. The report indicated ULP-B took relieved ULP-A of their duties, and ULP-A's employment ended because of her conduct. R1's "Service Delivery of Care Record" indicated ULP-A continued to provide services for the resident and worked the remainder of the scheduled shift on September 21, 2021, following ULP-B's reported allegation of physical and verbal abuse. In addition, ULP-A's time sheet and R1's medical record indicated ULP-A also worked the following day and continued providing services and care for R1. The facility failed to protect R1 and other vulnerable adults in the facility by allowing ULP-A to continue providing care to residents in the facility. On January 6, 2021, at 10:00 a.m. administrator-G stated the resident should have	0 620		

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0 620	Continued From page 3 been protected from recurring abuse by removing ULP-A from her duties while an investigation was completed of the alleged incident. Facility Policy titled "Vulnerable Adults -Keeping our Residents Safe" dated July 21, 2021, defined abuse and indicated verbal abuse was repeated conduct that produced mental or emotional stress including screaming, cursing, humiliation, threatening, degrading a vulnerable adult. The policy lacked guidance for staff to protect the resident from abuse by reporting the incident and removing the perpetrator. Facility Policy titled "Reporting Process" dated July 21, 2021, indicated after an investigation was completed and it was determined a report should be made, then they would then file a report with the Minnesota Adult Abuse Reporting Center (MAARC) immediately (with in 24 hours). The policy indicated if a staff member felt a resident had been abused, they must intervene to protect the resident, and report the incident immediately to the housing director, manager, or registered nurse (RN) without delay. The policy failed to direct the facility to protect the resident to include removal and suspension of the perpetrator pending investigation, and immediate reporting of an allegation of or suspected abuse to MAARC immediately, then complete a thorough investigation of the incident. Facility policy and procedure titled "Emergency and Immediate Notification Registered Nurse Manager" dated March 19, 2019, indicated ULP should notify the RN in all emergencies immediately. The procedure instructed staff to call the administrator with staffing issues and to call the RN for medical emergencies then the administrator. The policy does not include	0 620		

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0 620	Continued From page 4 guidance for staff to contact leadership for abuse or safety concerns. Time Period for Correction: Fourteen (14) days.	0 620		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500		

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01500	Continued From page 5 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure all employees had at least eight hours of annual training for each 12 months of employment that included required training on reporting of maltreatment of vulnerable adults under section 626.557 for one of four employees, unlicensed personnel (ULP)-B, employee records reviewed. This had the potential to effect all 14 residents receiving care from the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or	01500		

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01500	Continued From page 6 safety but had the potential to have harmed a client's health or safety), 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 clients). The findings include: Unlicensed personnel (ULP)-B was hired on September 9, 2020, and received abuse training at the time of hire. ULP-B's employee record indicated training was completed on October 8, 2020, but lacked evidence of annual training to include training on reporting of maltreatment of vulnerable adults. On December 28, 2021, at 3:23 p.m. ULP-B stated she had training on identifying and reporting abuse when she was hired, but had received no annual training. The facility policy titled "Vulnerable Adults - Maltreatment, Communication, Prevention and Reporting Plan" indicated all staff were provided training regarding their obligations to report suspected maltreatment to the housing director/manager, registered nurse, and Minnesota Adult Abuse Reporting Center. The policy failed to indicated staff would complete the training for each 12 months of employment. Time period for correction: Fourteen (14) days.	01500		
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	02360		

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02360	Continued From page 7 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to one of one resident reviewed (R1) was free from maltreatment. R1 was verbally and physically abused. Findings include: On December 14, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person and facility were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
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	03000		

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03000	Continued From page 8 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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of suspected abuse for one of one resident (R1), reviewed with allegations of abuse.	03000		

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03000	Continued From page 9 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 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). The findings include: R1 was admitted to the facility on May 18, 2021, with diagnoses including Alzheimer's Disease, Dementia, and Chronic Pain Syndrome. R1's service agreement dated August 31, 2021, indicated he utilized hospice services and required assistance with dressing, grooming, toileting, and mobility. R1's care plan indicated he was cognitively impaired and required reorientation and redirection, could become anxious and would call out for help at night for staff to sit with him. R1's Individual Abuse Prevention Plan dated May 18, 2021, indicated he was at risk for being abused due to not able to report abuse, or identify if he was in a unsafe situation. The plan directed staff to monitor and remove the resident from any abuse. An incident report dated September 21, 2021, at 6:00 p.m. indicated the administrator documented unlicensed facility personnel (ULP)-A had reported witnessing another staff being verbally and physically aggressive with R1.	03000		

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03000	Continued From page 10 On September 23, at 1:53 p.m. the facility filed a report with MAARC, three days after the incident occurred. On January 6, 2022, at 10:00 a.m. administrator-G stated ULP-A had texted him about the incident on the evening of September 21, 2021, then he gathered more information from her the following day. He completed an investigation over the next two days, and then reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC). The administrator indicated the facility policy was to investigate first then determine if the incident was required to report. The facility Policy titled "Reporting Process" dated July 21, 2021, indicated the facility would report after an investigation was completed and it was determined a report should be made, then they would then file a report with the MAARC immediately with in 24 hours. The policy indicated if a staff member felt a resident had been abused, they must intervene to protect the resident, and report the incident immediately to the housing director, manager, or RN without delay. The policy failed to direct the facility to protect the resident to include removal and suspension of the perpetrator pending investigation, and immediate reporting of suspected abuse to MAARC, then complete a thorough investigation of the incident. Time Period for Correction: Fourteen (14) days.	03000		
03030 SS=G	626.557 Subd. (4,a) Internal reporting of maltreatment (a) Each facility shall establish and enforce an ongoing written procedure in compliance with	03030		

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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
03030	Continued From page 11 applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. (b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure allegations of staff to resident abuse was reported and investigated timely for one of one resident, R1, reviewed for abuse. Staff had witnessed unlicensed staff (ULP)-A repeatadly abuse R1 but did not intervene. This resulted in on-going abuse to R1.	03030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30498	A. BUILDING: _____ B. WING _____	C 12/30/2021

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03030	Continued From page 12 This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on May 18, 2021, with diagnoses including Alzheimer's Disease, Dementia, and Chronic Pain Syndrome. R1's service agreement dated August 31, 2021, indicated he utilized hospice services and required assistance with dressing, grooming, toileting, and mobility. R1's care plan indicated he was cognitively impaired and required reorientation and redirection, could become anxious and would call out for help. R1's Individual Abuse Prevention Plan dated May 18, 2021, indicated he was at risk for being abused due to not able to report abuse, or identify if he was in a unsafe situation. The plan directed staff to monitor and remove the resident from any abuse. An incident report dated September 21, 2021, at 6:00 p.m. indicated the administrator documented facility staff had reported witnessing another staff being verbally and physically aggressive with the resident.	03030		

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03030	Continued From page 13 An employee discipline report dated September 21, 2021, indicated the day of the incident ULP-B witnessed and reported ULP-A was physically and verbally aggressive with the resident while assisting him to use the toilet. ULP-B reported she observed the ULP-A squeeze and shove and punch the resident's male genitalia into a toilet riser causing the resident to scream out in pain, then yelled at the resident in an aggressive manner. On December 14, 2021, at 3:30 p.m. ULP-C stated one morning when she came into work the resident was in a recliner chair by the front desk and ULP-A was standing over R1 leaning into his face yelling at him "shut the hell up go to sleep, this is stupid". ULP-C stated ULP-A was visibly upset and agitated with R1 and appeared very angry with a flushed complexion. ULP-C stated ULP-A was verbally abusive and yelled at the resident in a threatening manner, and reported ULP-A's abusive behavior, however a review of facility provided incident reports indicated there were no other allegations of abuse reported. On December 14, 2021, at 3:56 p.m. ULP-D stated she witnessed ULP-A repeatedly verbally abuse R1 and was "short tempered" by yelling at the resident in an aggressive manner. ULP-D stated ULP-A would frequently get frustrated and yell at R1 in an aggressive tone right in his face at least one time per shift if not multiple times. ULP-D stated she had expressed she did not think ULP-A was a good fit for the facility, but did not report the repeated verbal abuse of R1. On January 6, 2021, at 10:00 a.m. administrator-G stated there were no other reports or concerns of ULP-A having abusive conduct towards R1 prior to the incident on	03030		

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03030	Continued From page 14 September 21, 2021. Administrator-G stated he would have expected staff to report any concerns of abuse immediately, and the resident should have been protected from recurring abuse by removing ULP-A from her duties while an investigation was completed. WHEN SHOULD HE HAVE REMOVED ULP-A AND DIDNT? Facility Policy titled "Vulnerable Adults -Keeping our Residents Safe" dated July 21, 2021, defined abuse and indicated verbal abuse was repeated conduct that produced mental or emotional stress including screaming, cursing, humiliation, threatening, degrading a vulnerable adult. Facility Policy titled "Reporting Process" dated July 21, 2021, indicated the facility would report after an investigation was completed and it was determined a report should be made, then they would then file a report with the Minnesota Adult Abuse Reporting Center (MAARC) immediately (with in 24 hours). The policy indicated if a staff member felt a resident had been abused, they must intervene to protect the resident, and report the incident immediately to the housing director, manager, or RN without delay. The policy failed to direct the facility to protect the resident to include removal/suspension of the perpetrator pending investigation, and immediate reporting of an allegation of or suspected abuse to MAARC immediately, then complete a thorough investigation of the incident. Facility policy and procedure titled "Emergency and Immediate Notification Registered Nurse Manager" dated March 19, 2019, indicated the HHA should notify the RN in all emergencies immediately. The procedure instructed staff to call the administrator with staffing issues and to call the RN for medical emergencies then the	03030		

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03030	Continued From page 15 administrator. The policy does not include guidance for staff to contact leadership for abuse or safety concerns. Time Period for Correction: Fourteen (14) days.	03030		