

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31417001M
Compliance #: HL31417002C

Date Concluded: December 7, 2021

Name, Address, and County of Licensee

Investigated:

Elmore Assisted Living
202 East North Street
Elmore, MN 56027

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

Evaluator's Name: Julie Serbus, RN
Rapid Response Evaluator

Finding: Substantiated, 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: A resident was abused when the alleged perpetrator (AP) struck the resident and used inappropriate language in retaliation.

Investigative Findings and Conclusion:

Abuse was substantiated. The AP was responsible for the maltreatment. While assisting the resident with cares, the AP, who is an unlicensed personnel (ULP), slapped the resident twice. Two other ULPs witnessed the AP slap the resident.

The investigation included interviews with facility staff, nursing staff, and the assisted living director (ALD). The investigation included an onsite visit, review of facility incident reports and internal investigation. The investigation included a review of the resident's medical records and

an interview of one of the resident's family members. The investigation included an interview of the AP.

The resident's diagnoses included deafness, dementia, and bipolar disorder. The resident medical records indicated the resident can speak but chooses not to and communicates with staff through sign language or use of a white board. The resident's service plan indicated the resident required assist of two ULPs to assist with dressing, transfers, and toileting while he used a wheelchair for mobility. The resident's medical record indicated the resident can be physically aggressive towards staff including biting, pinching, and hitting while directing staff to use caution when providing cares.

The facility internal investigation indicated the AP and ULP-B stood on either side of the resident to help him stand while ULP-C changed the resident's incontinence pad. The same document indicated the AP lifted her arm and hit the resident across the back and then resident bit the AP's hand. The same document indicated the AP then slapped the resident across the face and said, "I fucking hate you" and called him a "fucker".

During an interview, ULP-B stated she was on the right side of the resident and the AP was on the left side. ULP-B stated she saw AP bring her arm back and hit the resident on the back. ULP-B stated the resident then bit the AP's hand, the AP slapped the resident's mouth, and then the AP said to the resident she hoped he liked her blood. ULP-B stated the AP later told her she would get ULP-B fired if she told anyone what happened. ULP-B stated she observed an occasion when the AP approached the resident and he backed away from her in his wheelchair and said the resident did not like her. ULP-B stated the resident did not sustain any bruises or cuts from the AP hitting him.

During an interview, ULP-C stated she helped change the resident's incontinence pad while the AP and ULP-B stood on either side of him. ULP-C stated saw the AP hit the resident on the back and heard the AP tell the resident she hoped he liked her blood, which indicated to ULP-C he had bit the AP. ULP-C stated the AP then yelled at the resident to not "fucking" bite her, so ULP-C asked her to leave the room. ULP-C stated the resident sat down after this and expressed himself by "flip[ping] us off".

During an interview, the AP stated three staff were required to stand and change the resident. The AP stated she was on the side of the resident with her hand resting over his wrist and as the AP looked down at ULP-C, the resident then bit the AP's hand. The AP stated there was pain and she was angry, but she did not hit or swear at the resident.

In conclusion, 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2

"Abuse" means:

(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: no, not able to be interviewed

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility: Both ULP-B and ULP-C received re-training on reporting abuse.

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 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 Development Disabilities
Faribault County Attorney
Faribault City Attorney
Faribault Policy Department
Faribault County Sherriff's Department
Elmore Police Department
The Minnesota Nurse's Aide Registry

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2021
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NAME OF PROVIDER OR SUPPLIER ELMORE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST NORTH STREET ELMORE, MN 56027
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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>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On October 4 through October 8, 2021 the Minnesota Department of Health initiated an investigation of complaint #HL31417001M/#HL31417002C . At the time of the investigation, there were #46 clients receiving services under the assisted living facility with dementia care license.</p> <p>The following correction orders are issued for #HL31417001M/#HL31417002C, tag identification 2350 and 2360.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>However, please document steps taken for correction as those records may be requested by MDH for licensing order follow-up.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000	subd. 1, 2, and 3.	
0 450 SS=G	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>All assisted living facilities shall:</p> <p>(1) distribute to residents the assisted living bill of rights;</p> <p>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;</p> <p>(3) utilize a person-centered planning and service delivery process;</p> <p>(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interviews, and record review, the licensee failed to ensure person-centered service delivery for one of one resident (R1) reviewed when the unlicensed personnel (ULP)-E slapped the resident on the back and face while addressing the resident as "fucker"</p> <p>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).</p> <p>Findings Include:</p>	0 450		

Minnesota Department of Health

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0 450	<p>Continued From page 2</p> <p>R1's medical record was reviewed. R1's medical diagnoses included deafness, dementia, and bipolar disorder. R1's medical record indicated he uses sign language or a white board to communicate. R1's service plan dated August 1, 2021, indicated R1 received assistance with dressing, toileting, and transfers.</p> <p>A facility internal investigation dated September 10, 2021, indicated ULP-E and ULP-B stood on either side of the resident to help him stand while ULP-C changed R1's incontinence pad. The same document indicated ULP-E lifted her arm and hit R1 across the back and then resident bit the ULP-E's hand. The same document indicated ULP-E then slapped R1 across the face and said, "I fucking hate you" and called him a "fucker". The sane document indicated ULP-E quit.</p> <p>During an interview on October 22, 2021, at 10:29 a.m., ULP-C stated she helped change R1's incontinence pad while the ULP-E and ULP-B stood on either side of him. ULP-C stated she saw ULP-E hit R1 on the back and heard ULP-E tell the client she hoped he liked her blood, which indicated to ULP-C he had bit ULP-E. ULP-C stated ULP-E then yelled at R1 to not "fucking" bite her, so ULP-C asked her to leave the room. ULP-C stated the resident sat down after this and expressed himself by "flip[ping] us off".</p> <p>During an interview on October 25, 2021, at 12:35 p.m., stated she was on the right side of R1, and ULP-E was on the left side. ULP-B stated she saw ULP-E bring her arm back and hit the resident on the back. ULP-B stated the resident then bit the ULP-E's hand, ULP-E slapped the resident's mouth, and then ULP-E said to the resident she hoped he liked her blood.</p>	0 450		

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0 450	Continued From page 3 The licensee's policy titled Assisted Living License Resource Manual dated August 1, 2021, indicated the facility prohibits the maltreatment of residents including abuse. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 450		
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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was abused. Findings include: On November 8, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that one individual staff person was 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		