Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL32084027M
Compliance #: HL32084028C

Date Concluded: July 1, 2021

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
202 North Street East
Elmore, MN 56027
Faribault County

Facility Type: Home Care Provider

Investigator's Name: Laura duCharme, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
An investigator from 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 client was abused when, the AP (Alleged Perpetrator) hit and kicked him.

Investigative Findings and Conclusion:
Abuse is substantiated. The AP was responsible for the maltreatment. Two witnesses saw the AP kick the client's leg and hit the client with an open hand in the back of the head and shoulder during cares, which caused the client to become more upset, agitated, and combative. The client was also noted to have a bruise on his left hand, which he indicated, was where the AP had pinched him.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator reviewed the client's medical records, incident reports, employee training, personnel records, policies, and procedures.

The client resided in the memory care unit at the facility. The client's diagnoses included, but was not limited to, deaf-nonspeaking, dementia with behavioral disturbance, bipolar disorder,

and diabetes mellitus type 2 with diabetic neuropathy. The client was non-verbal but could make most needs known by using sign language, gestures, reading lips, and writing. Staff were instructed to use sign language or paper and pen to communicate. He received staff assistance with medication management, transfers, bed mobility, behavior management, and toileting.

The client's service plan at the time of the incident included a behavior management plan with interventions directing staff to watch for behaviors related to communication frustration, support the resident to feel comfortable and safe in his environment, and re-approach when exhibiting behaviors, as the client would often calm down after being left alone.

Review of the facility's internal investigation indicated two staff witnessed the client hit and kick the AP during cares and offered the AP their assistance. While assisting with personal cares, the witnesses observed the AP kick at the client's feet and hit him in the back. A bruise was noted on the client's hand. The client later identified that the AP had pinched him there and was being mean. Additionally, the investigation noted the AP did not deny hitting or kicking the client but that the AP indicated the client had kicked her first. The facility considered the two staff witnesses credible reporters and substantiated the incident following the investigation.

When interviewed, ULP #1 stated she witnessed the AP trying to get the client into his room for toileting assistance and that the client was hitting at the AP. ULP #1 stated she observed the AP kicking the client's legs while assisting to get the client in his room. ULP #1 stated ULP #2 also entered the room to assist. While ULP #1 and ULP #2 were trying to calm the client down, ULP #1 observed the AP hitting the client on the shoulder and back. ULP #1 described the hit as an open slap. ULP #1 stated the client put himself on the ground and the AP kicked the client's legs a second time. ULP #1 stated the client responded by becoming more agitated, aggressive, and more or increasingly difficult to provide cares for. ULP #1 stated she immediately reported the incident to the charge nurse.

When interviewed, ULP #2 stated s/he witnessed the client was combative and was hitting and kicking and that the AP kicked back at the client. ULP #2 stated, after the AP began cares, the AP stood behind the client and hit him in the head and back. Once the client was seated back in his chair, ULP #2 stated the AP hit the client a second time. ULP #2 described the hits as open handed and the intensity as being more than a "tap" but not a "hard aggressive" hit. ULP #2 stated The AP's behavior toward the client made the client more agitated. ULP #2 stated she immediately reported the incident to the charge nurse.

When interviewed, the AP stated the client indicated he needed to be toileted and that he began hitting her while she was pushing his wheelchair into his room. The AP stated the client grabbed her hand so she "tapped" on his hand indicating to get his hand off of hers, but he grabbed harder, so she had to "pry" the client's hand off. The AP stated the client kicked at her, so she took her foot and reached over and touched his leg "as a mock". The AP denied kicking

or hitting the client and instead described her behavior toward the client as a “touch and not to be mean” and “play a little game”.

Review of the AP’s employee record indicated training included but was not limited to, abuse and neglect prevention, approaching care for difficult behaviors and dementia care. The AP had one prior facility investigation regarding “inconsiderate care” of a resident, which resulted in corrective action.

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:
(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;
(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: No, refused.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP is no longer employed by the facility.

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.

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
Faribault County Attorney
Elmore City Attorney
Elmore Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32084	A. BUILDING: _____ B. WING _____	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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. INITIAL COMMENTS: On June 21, 2021, a complaint investigation was initiated to investigate complaint #HL32084027M/HL32084028C. The following correction order is issued.	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 Home Care 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 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 investigators ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(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 licensing order follow-ups. 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. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under	0 325		

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0 325	Continued From page 1 chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors 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 clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On July1, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an 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.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	