Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33426001M
Compliance #: HL33426002C

Date Concluded: January 11, 2022

Name, Address, and County of Licensee Investigated:
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jeri Gilb, RN, MSN, CNP
Special Investigator

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): The Alleged Perpetrator (AP), facility staff, verbally and emotionally abused the resident.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP admitted to getting frustrated with the resident and arguing, yelling, and swearing at the resident. The resident experienced emotional distress during and after the incident.

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

Resident (R)1's medical record indicated diagnoses of generalized anxiety, post-traumatic stress disorder (PTSD), diabetes mellitus (DM 2) with polyneuropathy, asthma, and weakness.

R1 required staff assistance with meal preparation, mobility, medication management, hygiene assistance, housekeeping, and laundry services.

During interview, the AP admitted she was frustrated with R1 because the resident was picky and changed her mind about meals frequently. R1 requested a sandwich instead of the lunch on the menu. The AP stated she rolled her eyes and asked the resident why she was trying to make her job more difficult. Later that day, the facility registered nurse (RN) met with the AP to discuss the situation regarding her getting frustrated with the resident and how the AP could improve the resident(s) dining experience. Later that evening, the resident was in the dining room and the AP stated she asked the resident why she told the RN on her. The AP told the resident she did so many nice things for her; and the resident "still" told on the AP. The AP stated the resident replied and told the AP its her job to assist the resident with meals. The AP stated the interaction between herself, and the resident escalated into an argument and the AP told the resident to "Go fuck yourself!" The AP stated she knew it was wrong to yell and swear at the resident and was worried she may lose her job.

When interviewed, facility staff reported hearing the AP yell and swear at R1. Facility staff stated the resident was upset and crying after the AP yelled and swore at her. The resident did not want to report the AP to administration because she was afraid of retaliation from the AP. The facility staff stated the AP frequently became upset with residents and would yell and swear at them and staff. For days after the incident, the resident was very quiet and did not take her meals in the dining room and instead would eat in her room. Staff stated shortly after the incident when the AP yelled and swore at R1, the AP retaliated by deliberately leaving condiments off R1's meal tray. The facility staff informed the AP the resident requested specific condiments on her meal tray and the AP said "No." Facility staff stated the AP was still angry at the resident and was deliberately removing the condiments out of spite. Facility staff delivered the meal tray to the resident's room and the resident requested the condiments again. The staff member returned to the kitchen and asked for AP for the condiments again. The AP replied "No! If R1 wants it, you get it for her yourself." Facility staff reported the incident to administration.

Administration did not respond to requests for interview.

In conclusion, emotional abuse was substantiated. The AP swore, yelled, and intimidated the resident.

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;

(**Vulnerable Adult interviewed**: No, attempted but did not reach.

Family/Responsible Party interviewed: No, own guardian

Alleged Perpetrator interviewed: Yes

Action taken by facility: No action taken by 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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Benton County Attorney
Sauk Rapids City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	C 11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	**1420 2ND STREET NORTH SAUK RAPIDS, MN 56379**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an 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. INITIAL COMMENTS: On November 9, 2021, the Minnesota Department of Health initiated an investigation of complaint ##HL33426002C/#HL33426001M. At the time of the investigation, there were #14 clients receiving services under the assisted living license. The following correction orders are issued for #HL33426002C/#HL33426001M, tag identification 0620, 2360, and 3000.	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 record review, the licensee failed to report or investigate allegations of emotional and verbal abuse of one of one resident (R1) who alleged a staff member emotionally and physically abused them. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Findings include: R1's medical record indicated diagnoses of generalized anxiety disorder, post-traumatic stress disorder, lumbar spinal stenosis, and weakness. R1's service plan dated May 3, 2021, indicated the resident required assistance with meal preparation, medication management, assistance with bathing, dressing, hygiene, and assistance	0 620		

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0 620	Continued From page 2 with transfers and mobility. During an interview on November 19, 2021, at 12:02 p.m., Unlicensed Personnel (ULP)-A stated she and R1 had a disagreement in the dining room. ULP-A stated she rolled her eyes at R1 and then asked the resident why she liked to make her job more difficult. R1 asked for a different menu item for lunch than what the facility served for the day. ULP-A stated R1 told registered nurse (RN)-E about the argument she had with R1, and RN-E spoke to ULP-A about ways to improve the dining experience for the residents. That evening, R1 and ULP-A were both in the dining area. ULP-A stated she and R1 started to argue again. ULP-A stated she "lost her cool" and told R1 to, "go fuck herself." ULP-A stated she recognize it was wrong to argue and swear at R1, and she was afraid the facility was going to fire her. During an interview on December 15, 2021, at 4:00 p.m., ULP-D stated she heard R1 ask for a sandwich instead of the lunch served the day of the incident. ULP-A approached R1 and asked why she had to be so picky. R1 reported this argument to another resident and ULP-D. Later that evening, ULP-D overheard ULP-A and R1 in the dining room and heard ULP-A tell R1 to "fuck off." ULP-D stated after the interaction R1 was distraught and crying after ULP-D yelled and swore at her. R1 told ULP-D she did not want this reported to administration because she was afraid that ULP-A would retaliate against her. ULP-D reported the incident to RN-E, and ULP-A told ULP-D she apologized to R1 to keep her job. ULP-D stated approximately one month later,ULP-D saw ULP-A take condiments off R1's tray at dinner. When R1 requested them, ULP-D went back to the kitchen to ask for them. ULP-A	0 620		

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0 620	Continued From page 3 replied, "No. If [R1] she wants them, get them yourself." ULP-D stated R1 was very quiet and did not take her meals in the dining room for 3 days after ULP-A yelled and swore at her. During an interview on November 22, 2021, at 1:03 p.m., ULP-B stated she heard ULP-A loudly arguing with different residents multiple times at the facility. ULP-B tried to discuss the issues with administration, but no one would listen to her. R1 and ULP-A both told ULP-B about the incident. R1 cried when telling her ULP-A yelled at her and told her to "fuck off". In an email dated November 27, 2021, RN-E stated she gave all the information to Administration (Admin-F) to handle the report, internal investigation, and discipline of ULP-A. In a follow up email dated November 29, 2021, RN-E stated it was given to Admin-F the day staff notified her of the incident. RN-E is unsure of the incident date and no longer works at the facility. In an email dated December 14, 2021, administrator (A)-F stated the date of the incident was was September 17, 2021. The facility had no investigation, the incident was not reported to the state agency, and there was no indication ULP-A was disciplined or re-educated about the alleged incident. requests for internal investigation and discipline records for ULP-A were not provided. The facility Vulnerable Adult policy, undated, indicated staff are to notify the Clinical Nurse Supervisor and the Assisted Living Director of any suspicion of abuse. The Assisted Living Director or Clinical Nurse Supervisor will confirm if there is a suspicion of maltreatment and report to the Minnesota Adult Abuse Reporting Center no later than 24 hours after the maltreatment is	0 620		

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0 620	Continued From page 4 suspected. The facility will work with police, OHFC investigators, and others in the investigation of the suspected maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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 reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On January 4, 2022, 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
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	03000		

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03000	Continued From page 5 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 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	03000		

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03000	Continued From page 6 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 observation, interview, and record review, the licensee failed to report or investigate emotional and verbal abuse allegations for one of one resident (R1) who alleged emotional and verbal abuse by a staff member. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's medical record indicated diagnoses of generalized anxiety disorder, post-traumatic stress disorder, lumbar spinal stenosis, and weakness. R1's service plan dated May 3, 2021, indicated the resident required assistance with meal preparation, medication management, assistance with bathing, dressing, hygiene, and assistance with transfers and mobility. During an interview on November 19, 2021, at 12:02 p.m., Unlicensed Personnel (ULP)-A stated she and R1 had a disagreement in the dining	03000		

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03000	Continued From page 7 room. ULP-A stated she rolled her eyes at R1 and then asked the resident why she liked to make her job more difficult. R1 asked for a different menu item for lunch than what the facility served for the day. ULP-A stated R1 told registered nurse (RN)-E about the argument she had with R1, and RN-E spoke to ULP-A about ways to improve the dining experience for the residents. That evening, R1 and ULP-A were both in the dining area. ULP-A stated she and R1 started to argue again. ULP-A stated she "lost her cool" and told R1 to, "go fuck herself." ULP-A stated she recognize it was wrong to argue and swear at R1, and she was afraid the facility was going to fire her. During an interview on December 15, 2021, at 4:00 p.m., ULP-D stated she heard R1 ask for a sandwich instead of the lunch served the day of the incident. ULP-A approached R1 and asked why she had to be so picky. R1 reported this argument to another resident and ULP-D. Later that evening, ULP-D overheard ULP-A and R1 in the dining room and heard ULP-A tell R1 to "fuck off." ULP-D stated after the interaction R1 was distraught and crying after ULP-D yelled and swore at her. R1 told ULP-D she did not want this reported to administration because she was afraid that ULP-A would retaliate against her. ULP-D reported the incident to RN-E, and ULP-A told ULP-D she apologized to R1 to keep her job. ULP-D stated approximately one month later,ULP-D saw ULP-A take condiments off R1's tray at dinner. When R1 requested them, ULP-D went back to the kitchen to ask for them. ULP-A replied, "No. If [R1] she wants them, get them yourself." ULP-D stated R1 was very quiet and did not take her meals in the dining room for 3 days after ULP-A yelled and swore at her.	03000		

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03000	Continued From page 8 During an interview on November 22, 2021, at 1:03 p.m., ULP-B stated she heard ULP-A loudly arguing with different residents multiple times at the facility. ULP-B tried to discuss the issues with administration, but no one would listen to her. R1 and ULP-A both told ULP-B about the incident. R1 cried when telling her ULP-A yelled at her and told her to "fuck off". In an email dated November 27, 2021, RN-E stated she gave all the information to Administration (Admin-F) to handle the report, internal investigation, and discipline of ULP-A. In a follow up email dated November 29, 2021, RN-E stated it was given to Admin-F the day staff notified her of the incident. RN-E is unsure of the incident date and no longer works at the facility. In an email dated December 14, 2021, administrator (A)-F stated the date of the incident was was September 17, 2021. The facility had no investigation, the incident was not reported to the state agency, and there was no indication ULP-A was disciplined or re-educated about the alleged incident. requests for internal investigation and discipline records for ULP-A were not provided. The facility Vulnerable Adult policy, undated, indicated staff are to notify the Clinical Nurse Supervisor and the Assisted Living Director of any suspicion of abuse. The Assisted Living Director or Clinical Nurse Supervisor will confirm if there is a suspicion of maltreatment and report to the Minnesota Adult Abuse Reporting Center no later than 24 hours after the maltreatment is suspected. The facility will work with police, OHFC investigators, and others in the investigation of the suspected maltreatment.	03000		

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03000	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	03000		