Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52032102M **Date Concluded:** January 24, 2023

Name, Address, and County of Licensee Investigated:
The Villa at Bryn Mawr
275 Penn Ave. North
Minneapolis, MN 55405
Hennepin County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN - 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused a resident when she pinched the resident on the back of the right shoulder blade causing the resident to yell out in pain and the resident's right shoulder was observed to be reddened.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident reported to two nursing staff the AP pinched her and the resident had redness where the resident stated the AP pinched her. Another resident witnessed hearing the resident yelling out, "you pinched me" at the time of the incident. A preponderance of evidence indicated the abuse likely occurred.

The investigator conducted interviews with facility staff members including licensed and unlicensed nursing staff. The investigator contacted the resident's guardian. The investigation included review of resident records, progress notes, skin observation documentation, facility

investigation documentation, resident and staff witness statements, and prior investigation documentation and interviews.

The resident resided in a nursing home with diagnoses including Alzheimer ' s Disease, diabetes mellitus, major depressive disorder, and failure to thrive. The resident record indicated she was severely cognitively impaired and required a wheelchair for mobility.

The resident's care plan indicated the resident had a pattern of going to the last smoking break late and will become upset if she is not able to go out and will strike out at staff if not allowed. The care plan indicated staff were to give the resident space to cool down, instruct the resident on the smoking policy, and report the behavior to the charge nurse.

A progress note indicated the resident was heard by nursing staff yelling "you pinched me, you pinched me!" when the AP was escorting the resident's in from the smoking patio area. The nurse documented when the AP was asked why she pinched the resident, the AP stated the resident hit her in the chest, so she pinched her back.

A written statement by one nursing staff indicated the resident was heard yelling from the smoking area "she pinched me" and identified the AP. The statement indicated when the AP was asked why she pinched the resident, the AP stated the resident had hit her in the chest. Another nurse's written statement indicated the resident reported the AP had pinched her and pointed to her shoulder.

When interviewed a nurse stated the resident was crying, appeared upset, and reported the AP had pinched her then pointed to her shoulder blade area. The nurse stated when he observed the resident's shoulder blade it was reddened, and the resident reported the incident caused her pain. The nurse indicated the resident was a reliable reporter and he believed the resident was pinched by the AP.

A facility resident interview witness statement indicated the resident was heard yelling "you pinched me" as the residents were coming in from the smoking patio with the AP.

The resident's skin observation documentation, 39 minutes after the incident occurred, indicated redness was observed on the resident's right scapula (shoulder blade area on the back).

When interviewed the AP denied pinching the resident, and repeatedly stated she was assaulted and abused by 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:
(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, unable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and provided education to staff on actions to take with resident aggression. The facility reported potential maltreatment to the Minnesota Adult Abuse Reporting Center.

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

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
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00175	A. BUILDING: _____ B. WING _____	C 01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint # H52032102M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 H52032102M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as	21850		

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21850	Continued From page 2 authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 1 resident (R1) reviewed was free from maltreatment. R1 was abused. Findings include: The Minnesota Department of Health (MDH) issued a determination that abuse occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	