Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53606785M
Compliance #: H53602365C

Date Concluded: February 12, 2024

Name, Address, and County of Licensee Investigated:
Glen Oaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 65273
Kandiyohi County

Facility Type: Nursing Home

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
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 the resident when the AP shut a door on the residents' arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP denied closing the resident's arm in a door and there were not any witnesses to the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included dementia and depression. The resident's service plan included assistance with dressing and toileting. The resident's assessment indicated the resident did not have a history of refusing cares and the resident used a wheelchair for mobility.

The facility internal investigation indicated the AP was assisting the resident with cares when the resident sustained a large skin tear to his arm. The AP and the resident had different recollections on the cause of the skin tear.

During an interview, a nurse stated the resident has very good long-term memory, and good short-term memory in the immediate time frame of five to ten minutes. The nurse stated the resident reported to her the AP slammed his arm in the door. The nurse stated the resident did not recall the event the next day.

During an interview, an administrative nurse stated she felt the resident was reliable with the incident that occurred as he appeared visibly shaken. The nurse stated there had been no concerns voiced from resident about the AP prior to this incident. The nurse stated the resident told her he was waiting for help in his wheelchair in the doorway of his room when the AP came to him and shut his arm in the door. The nurse stated the AP said the resident hit his arm on his wheelchair.

During an interview, a social services staff member stated the resident was a reliable reporter on immediate current things and things from the long ago past. The staff member stated while she was in her office, she heard the AP yell "I don't need to put up with this," and heard a door slam. The staff member then heard the resident say, "I don't understand why this is happening, I don't know what is going on." The staff member stated the resident was hesitant to say what happened, and stated he did not want to get anyone in trouble. The staff member stated the resident recalled the incident the next day. The staff member stated the AP told her the resident was resisting care.

During an interview, unlicensed personnel (ULP 1) stated she previously witnessed the AP call another resident a derogatory name, talk back to supervisors and had poor work quality. ULP 1 stated the resident was a nice and happy guy who did not have history of resisting care. ULP 1 stated the AP told her she bumped the resident's arm on the door frame when taking the resident to the bathroom.

During an interview, ULP 2 stated the resident was not reliable reporter.

During an interview, a family member stated the resident does not have a good memory of current time and was not a reliable reporter. The family member stated the resident has fragile skin and accidently tore his skin in the past. The family member stated the resident receives good care at the facility.

During an interview, the AP stated she received abuse and neglect training throughout her employment. The AP stated the resident had memory issues and could not recall things after five minutes. The AP stated she was assisting the resident with getting ready for bed when he started to get combative and was holding his arms stiff straight down at his sides in the wheelchair. The AP said the resident obtained the skin tear when he then pulled his arms up from his sides and scraped his arm on the underside of the wheelchair arm rest. The AP stated she did not shut the resident's arm in the door. The AP stated the room doors closed prior to the time the injury occurred.

The resident was not able to complete an interview due to dementia.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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, unable due to dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and the alleged perpetrator is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 #H53606785M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		