Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53957124M
Compliance #: H53952849C

Date Concluded: March 5, 2024

Name, Address, and County of Licensee Investigated:
Crossroads Care Center
965 McMillan Street
Worthington, MN, 56187
Nobles County

Facility Type: Nursing Home

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Not Substantiated

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), facility staff, abused a resident when he told the resident to shut up in retaliation for the resident reporting the AP had not cleaned his room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP told the resident to shut up, the allegation did not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the facility investigation of the incident, staff personnel files, staff schedules, resident medical records, and facility policies and procedures.

The resident resided in a skilled care facility. The resident's diagnoses included schizoaffective disorder. The resident's service plan included assistance with grooming, dressing, bathing,

eating, medications, and housekeeping. The resident's assessment indicated the resident had cognitive deficits that required staff to provide positive interactions.

A facility investigation indicated the director of nursing received a message from one of the facility nurses indicating the AP had yelled at the resident to "shut up". When interviewed the AP stated the housekeeping supervisor told the AP the resident reported his room had not been cleaned all week. The AP stated the next time he worked with the resident he told the resident not to talk to him because he was not happy with him because he told housekeeping he had not cleaned the resident's room. The resident told the AP that was not true, and the AP stated he felt the resident was egging him on and he felt frustrated, so the AP told the resident to shut up and the AP left the resident's room.

The facility investigation indicated a nurse was interviewed and stated she was in the whirlpool room assisting a resident when she heard loud voices in the hallway. The nurse stated she saw the AP pushing his cleaning cart right outside of the resident's room and she heard the AP tell the resident to, "shut up." The nurse told the AP not to speak to residents that way and the AP told the nurse the resident was "lying."

During interview a nurse stated she was in the whirlpool room with another resident when she heard loud voices. She went into the hallway and heard the AP tell the resident to "Shut up" in a loud voice. The nurse stated she told the AP not to talk to the resident like that, and the AP left the unit. The nurse stated the resident did not seem to be in any distress.

The AP did not respond to requests for interview.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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: No, did not respond to subpoena

Action taken by facility:
The AP is no longer employed by the facility.
The facility made a report to the Department of Health

Action taken by the Minnesota Department of Health:

The facility was issued a federal deficiency for noncompliance with licensing requirements. For a copy of the Statement of Deficiencies, please call 651-201-4200.

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
	00407	A. BUILDING: _____ B. WING _____	C 01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

(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 #H53957124M/ #H53952849C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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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		