DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54464885M **Date Concluded:** May 1, 2023

Name, Address, and County of Licensee Investigated:
Assumption Home
715 North First Street
Cold Spring, MN 56320
Stearns County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator
Revised by: Benjamin Hanson
Revised date: January 15, 2025

Finding: Inconclusive

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 perpetrators (AP)s, AP-1, and AP-2, facility staff, abused a resident when they yelled and swore at the resident and discussed adult sex toys while assisting the resident with cares.

Investigative Findings and Conclusion:

Upon reconsideration of this report, the findings were changed from substantiated to inconclusive.
The Minnesota Department of Health determined abuse was inconclusive~~substantiated~~. AP-1 was witnessed by two staff repeatedly swearing at the resident and told the resident to, "Stand the fuck up, so I can wipe your ass!" AP-1 also discussed sexual preferences and the use of adult sex toys in front of the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of prior investigation documentation, facility investigation, interviews, AP personnel files, and resident medical records.

The resident resided in a nursing home with diagnoses including Alzheimer's Disease, dementia, traumatic brain injury, communication deficit, difficulty walking, and received hospice end of life services. The resident's comprehensive assessment indicated the resident was oriented to himself only, was rarely understood, and had difficulty expressing his needs. The resident required extensive assistance from staff with toileting.

A facility incident report indicated AP1 and AP2 were assisting another staff member with toileting the resident. A staff member reported they witnessed AP-1 and AP-2 have a conversation about adult sex toys in front of the resident. The staff member stated AP-1 yelled at the resident to, "Stand the fuck up so I can wipe your ass!"

The resident's progress notes, documented the day of the incident, indicated the resident was restless and anxious, and was hitting and forcefully grabbing staff's arms and hands when they were assisting the resident with toileting.

When interviewed the staff witness stated the resident tended to become agitated with toileting so she requested assistance from AP-1 and AP-2. The staff stated they were transferring the resident out of bed into his wheelchair and AP-1 yelled at the resident to, "Stand the fuck up". The staff stated AP-1 and AP-2 talked about adult sex toys while the resident was in the bathroom. The staff told AP-1 and AP-2 to stop talking about that in front of the resident. The staff stated the resident yelled at AP-1 and AP-2 to, "Knock it off!" The staff stated when they assisted the resident off the toilet the resident became agitated and forcefully grabbed and squeezed staff's arms and hands. The staff stated AP-1 looked the resident directly in the face and in a threatening manner yelled at the resident, "You need to stand the fuck up so I can wipe your ass!"

An emailed statement from AP-2 indicated AP-1 swore, "a couple of times on accident" while providing cares to the resident.

AP-1 was interviewed and denied the allegations.

During interview facility leadership stated AP-1 was verbally abusive to the resident. Leadership stated both AP-1 and AP-2 had inappropriate conversations about adult sex toys in front of the resident. However, AP-2 did not verbally abuse and swear at the resident, and the sexual comments were not directed at the resident.

In conclusion, abuse was inconclusive~~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, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: AP-1, Yes, AP-2, refused to respond to interview attempts.

Action taken by facility:
The facility suspended the APs pending the investigation, reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), investigated the allegation, and provided education to staff. The APs are no longer employed by the facility.

Action taken by the Minnesota Department of Health:

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Sterns County Attorney
Cold Spring City Attorney
Cold Spring Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00624	A. BUILDING: _____ B. WING _____	C 04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSUMPTION HOME	**715 NORTH FIRST STREET COLD SPRING, MN 56320**

(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 #H54464666M and H54464885M 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 #H54464666M and #H54464885M 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 2 of 2 residents (R1, and R2) reviewed were free from maltreatment. R1 was neglected, and R2 was abused. Findings include: The Minnesota Department of Health (MDH) issued a determination that abuse occurred, and an individual staff person(s) were 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.	