Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5513035M **Date Concluded:** April 15, 2022

Name, Address, and County of Licensee Investigated:
Lake Ridge Care Center
310 Lake Boulevard South
Buffalo, MN 55313
Wright County

Facility Type: Nursing Home **Evaluator's Name:** Peggy Boeck, 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.

Allegation(s):
It is alleged: The alleged perpetrator (AP), facility staff, verbally abused several residents when the AP swore, called them names, and yelled at a resident. It was also alleged the AP physically abused several residents when the AP was rough with cares.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. Witnesses observed the AP yell, swear at, and make degrading comments to several residents over the course of several hours. The witnesses observed the AP grab a resident (Resident 1) by the pants and shake him and forced a resident's (Resident 2) hands onto the grab bars while transferring the resident with a sit to stand lift. A resident (Resident 3) stated the AP "was rough" and upset her. Another resident (Resident 4) stated the AP grabbed his legs and threw him around, causing pain.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the AP's personnel file, resident

records, incident reports, the facility investigation, and policies and procedures related to staff code of conduct and maltreatment of vulnerable adults.

Resident 1 lived in the facility for less than a year due to diagnoses that included a fractured right leg, history of a stroke with weakness on the right side, and dementia. Resident 1 required assistance of one staff for transfers with a sit to stand mechanical lift.

Resident 2 lived at the facility for several years due to diagnoses that included osteoarthritis, dementia, diabetes, and pain. Resident 2 required assistance of two staff with a sit to stand lift for transfers.

Resident 3 lived at the facility for several months due to diagnoses that included a broken leg, diabetes, history of a stroke with left side weakness, and legal blindness. Resident 3 required assistance of one staff for showers, dressing, grooming and hygiene.

Resident 4 lived at the facility for less than a year due to diagnoses that included heart failure, prostate cancer, right knee pain, and left above the knee amputation. Resident 4 required assistance of two staff with a full mechanical lift for transfers.

According to a facility report, one morning Resident 1 attempted to self-transfer into his bed. The AP was in Resident 1's room and grabbed him by the pants and allegedly screamed at the resident, "What are you doing?" The AP proceeded to shake Resident 1 by his pants. The AP said to a staff, who was in the room, "I should slap him in the ass!" and called Resident 1 a "fucking dope."

The facility report also indicated the AP forced Resident 2's hands onto grab bars while transferring Resident 2 with a sit to stand lift. The report indicated a staff heard Resident 2 say to the AP, "Don't be so rough".

Staff who witnessed the incidents reported the incidents to the director of nursing.

The director of nursing contacted the administrator, who went to the facility to assure residents were safe, verified the incidents, and escorted the AP out of the building, pending investigation.

The facility investigation indicated several residents identified the AP as a staff who was rough with cares on the day of the incidents. Resident 3 stated the AP "was rough when she gave me a shower today" and noted "it upset me a lot" the way the AP treated her. Resident 4 stated the AP hurt his legs when the AP grabbed him and "pushed and shoved me back and forth".

During interview, a staff stated she witnessed the AP grab Resident 1 by the pants and shake him back and forth. The staff stated the AP raised her voice at Resident 1 and appeared to be angry. The staff stated she assisted the AP with getting Resident 3 ready for a shower, when the AP said, "what a fucking fat ass," in front of resident 3.

During interview, another staff stated she witnessed the AP grab Resident 2's hands and slap them onto the grab bars of the sit to stand lift. The staff stated that during the same shift, she could hear the AP being rough with Resident 4 on the other side of a curtain in the same room. The staff member stated the resident made sounds of discomfort and told the AP, "You are hurting my leg."

During an interview, a nurse stated Resident 3 and Resident 4 told her the AP was rough with them and they never wanted the AP to work with them again.

During an interview, the director of nursing stated several complaints made by staff about a toxic work environment led the administration to transfer the AP to a different section of the facility prior to the incidents. The director of nursing stated the facility investigation began on the day of the incidents by gathering resident statements and two days later they conducted a full investigation. The director of nursing stated the AP's behavior was shocking.

The AP's personnel file indicated disciplinary action several years prior related to reports of verbal abuse. At that time, the AP completed mandatory counseling to improve communication with residents and coworkers as a condition of continued employment.

During an interview, the AP stated she did not recall Resident 1 but probably tried to prevent him from falling. The AP stated she gently guided Resident 2's hands onto the grab bars of the sit to stand lift. The AP stated she did not say mean things to Resident 3. The AP stated she did not recall Resident 4 expressing pain when she moved him. The AP stated she did not know how any resident would interpret her cares as rough, but stated she had a personality conflict with a resident and that was why the administration moved the AP to a different work area. The AP stated she heard about once a year from co-workers her tone [of voice] was aggressive and then they would laugh together.

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, none of the residents were interviewed.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works at the facility.
The facility re-educated all staff on the importance of careful and gentle handling of residents per the Vulnerable Adult Abuse Prevention policy. The Director of Nursing planned to conduct audits of staff cares by interviewing residents.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(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 #H5513035M, 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	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The	

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2 000	Continued From page 1 #H5513035M, 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	state statute/rule number and the corresponding text of the state statute/rule number out of compliance are 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 evidenced by." Following the evaluators findings are the Suggested Method of Correction and the 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 authorized in writing after examination by a	21850		4/22/22

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21850	Continued From page 2 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 four of four residents reviewed (R1, R2, R3, and R4) wer free from maltreatment. R1, R2, R3, and R4 were abused. Findings include: On April 15, 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.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. Reviewed	