Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56264701M
Compliance #: H56265229C

Date Concluded: October 7, 2024

Name, Address, and County of Licensee Investigated:
Rochester Rehab and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901
Olmsted County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, 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 AP neglected and abused resident 1 (R1) and resident 2 (R2) when R1 reported the AP had rude conduct then neglected R1 when the AP refused to provide cares. R2 was abused when she reported feeling afraid after the AP roughly handled and pinched R2 causing bruising.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were not substantiated. The AP was not working with R1 or R2 at the time of the alleged incidents, and the description of the AP was conflicting. R1 stated she did not feel threatened or afraid as a result of the incident. R2 denied the AP pinched her on purpose. The incidents did not rise to the level of neglect or abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident record(s), facility 5-day investigation report,

facility incident reports, complaints/grievances, personnel files, staff schedules, and related facility policy and procedures.

R1 resided in a skilled nursing facility with diagnoses including stroke with right sided weakness, chronic kidney disease, and generalized muscle weakness.

R1's assessment and service plan indicated she was cognitively intact, alert, and oriented with clear speech.

R1's complaint/grievance form indicated R1 rang for assistance to change her brief, but staff turned off the call light and refused to provide care to the resident. The resident reported the AP threw a blanket over the resident, then threw the call light at the resident and left.

The following day during a previous federal interview with R1, the resident stated she rang for assistance to use the bathroom, the staff appeared sad/crabby, and put her on the bed pan with only one blanket. The federal interview indicated the resident was provided toileting assistance.

When interviewed by the investigator the resident denied the incident made her feel afraid or bad. The resident stated staff threw the call light down but not at her, and indicated the staff person seemed upset but she did not feel like it was directed toward her. The resident described the staffs race, sex, and stature.

R1's service delivery of care record indicated the AP only provided services to the resident one time in the month of July, which was not at the time the incident occurred.

A review of the AP's time clock punches and facility schedule indicated the AP was not assigned to work with the resident at the time the incident occurred.

A facility provided photo of the staff person identified as the AP did not meet R1's description of the AP.

R2 resided in a skilled nursing facility with diagnoses including spinal stenosis lumbar region with neurogenic claudication, mild intellectual disability, anxiety disorder, and morbid obesity.

R2's assessment and service plan indicated she had moderate cognitive impairment and required 2 staff assistance with transfers and bed mobility.

R2's complaint/grievance form indicated the resident reported staff was rude to her and forced her to go to bed at 6:00 p.m. then pinched her arm. The resident stated she was afraid of the staff and described the AP's race, sex, and stature.

A facility provided photo of the staff person identified as the AP did not meet R2's description of the AP.

A previous federal interview with R2 indicated the AP was rough, bossy, pushy, and pinched R2.

When interviewed by the investigator R2 stated the AP forced her to go to bed at 6:00 p.m. but denied the AP had pinched her intentionally.

A review of the facility staffing schedule and AP time punches from the time of the incident indicated the AP was not scheduled to work with R2 at the time of the incident. The schedule indicated 2 other staff were assigned to the resident at the time the resident reported the incident occurred.

A previous federal interview with the 2 staff assigned to work with R2 at the time the incident occurred indicated the resident required 2 staff assistance with transfers and bed mobility. The staff stated R2 requested to go to bed around 6:00 p.m. the night of the incident. One staff stated they were still clearing supper trays when R2 stated "if you guys are ready, I am", so they went and helped R2 get ready for bed. The other staff confirmed the AP was working on another wing at the time the incident occurred. The staff stated she had observed several bruises on the resident, but the resident made no complaints of abuse or rough treatment.

The investigator requested facility investigation documentation of the incidents; none was provided. The facility provided a document identified as the 5-day incident investigation report which indicated a different AP was responsible, and the incident occurred on a different day. The report indicated the allegation involving R1 could not be verified or refuted because it was unclear whether or not the allegation occurred. The report indicated the AP denied the allegation. The report failed to include information about R2's incident or investigation.

When interviewed the nurse who received the initial resident allegations indicated R2 stated the AP was rough with her and she was afraid. The nurse stated the resident had not mentioned she was pinched until the following day, but she saw no signs of bruising.

When interviewed facility nursing leadership stated they had investigated the incidents but did not recall if the residents were reliable reporters, or if the AP accused was working with the residents at the time of the allegations.

In conclusion, the Minnesota Department of Health determined abuse and neglect were 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;

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, failed to respond to interview attempts.

Action taken by facility:
The facility interviewed residents and provided education to staff on identifying and reporting maltreatment.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	29822	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CI	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(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 #H56264701M, and #H56265229C, 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		