Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HG503006M **Date Concluded:** September 20, 2021

Name, Address, and County of Licensee Investigated:
Mount Olivet Rolling Acres
129 Mackenthun Lane
Norwood Young America, MN 55368

Facility Type: Intermediate Care Facility (ICF) **Evaluator's Name:** Yolanda Dawson, 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) verbally and physically abused the client when the AP yelled and pulled hard on the client's shirt collar to get him off the floor when he was sleeping.

Investigative Findings and Conclusion:
Physical abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. A staff member observed the AP yell in the client's face and yank hard on his shirt collar to get him off the floor, while the client was sleeping. Photos taken immediately following the incident showed red marks left around the client's neck.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The client's record was reviewed. Staff schedules, policies, procedures, and the facility's internal investigation were reviewed. The AP did not respond to a subpoena for an interview.

The client's diagnoses included profound intellectual disability, epilepsy, osteoporosis, and congenital scoliosis. The client received services from the home care provider that included

medication management, internal feeding management, toileting assistance, hygiene assistance, and dressing assistance.

Review of internal investigation documents indicated that facility leadership interviewed staff members after the incident, and staff reported numerous concerns with the AP's previous behavior. One staff member reported she would delay the bedtime routine with clients to avoid the AP, and the AP would yell at clients. Another staff member reported the AP complained and yelled and tried to keep clients in bed and tell them they could not get up yet. A third staff member reported the AP was crabby, impatient, and forceful with her tone. A supervisor reported that staff complained about the AP and the AP was often loud and abrasive. Of the eleven interviews, two staff and one supervisor reported they heard the AP had chased clients with a broom, however none of them witnessed that incident.

Also during the interviews conducted by facility leadership, a management staff member stated the AP had a temper and on the evening of the incident she felt it was important not to go into the house alone and requested police presence, however, they declined.

During the internal investigation, the AP told facility management she grabbed the client and held him by the back of his shirt between the shoulder blades. She told the client to stand up. The AP stated she grabbed the client's face to look into his eyes to see if he was having a seizure. She stated the third time she said something to the client he smiled, and she told him it was not funny. The AP denied chasing clients with a broom.

Review of five photos, taken by a staff member immediately after the incident, showed red marks on the front and back of the client's neck, and upper right arm.

During an interview a part of this investigation, a staff member (Staff #1) stated the client was asleep on his bedroom floor, and she asked the AP to help her get him up. Staff #1 stated she thought they would each take an arm and assist the client up. However, the AP began to yank on the client's shirt collar and screaming in his face, not giving him time to wake up. Staff #1 stated she could tell the client was in pain because he scrunched up his nose which is what he did when he is in pain. Staff #1 stated the AP continued to yank and to scream at the client. When the client was near his bed, staff #1 told the AP she could finish on her own and the AP left the room. Staff #1 stated she boosted the client up into bed and apologized to him. Afterward the client was in bed, staff #1 could see that he had a red ring around his entire neck.

During an interview, a member of management staff said staff #1 reported to her the AP had yelled in the client's face to "get up, I know you're not dumb!" The AP grabbed on the client's shirt collar hard, and the client tried to get up by holding the television stand and staff #1 could see he was in pain. Immediately following the incident, staff #1 used her personal phone to take pictures of the client's neck. The management staff member stated the AP was loud and was too harsh in her tone.

The AP was not interviewed during this investigation because she did not respond to the subpoena.

In conclusion, abuse was substantiated. The AP's conduct towards the client caused physical pain, and was not an accident or therapeutic conduct.

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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, client is nonverbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, did not respond to subpoena.

Action taken by facility:
Retraining on maltreatment for all staff at the house. Training for documentation consistency. Review of maltreatment prevention policy. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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
Carver County Attorney
Norwood City Attorney
Carver County Sheriff's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21000	A. BUILDING: _____ B. WING _____	09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG503006M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued are issued for HG503006M, tag identification 0700.	5 000	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 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"	

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5 000	Continued From page 1	5 000	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 investigators ' findings is 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.	
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS 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 nontherapeutic 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 nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as 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.	5 700		

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5 700	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On September 20, 2021, 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.	5 700	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	