Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202917064M
Compliance #: HL202913448C

Date Concluded: October 20, 2023

Name, Address, and County of Licensee Investigated:
Benedictine Living Community
135 Pioneer Road
Red Wing, MN 55066
Goodhue County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Deb Schillinger, RN Special Investigator
Christine Bluhm, 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) abused the resident when she forcefully showered him while restraining his hands after an incontinence episode.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Two unlicensed caregivers (caregiver #1 and caregiver 2) were trying to provide the residents cares after an incontinence episode, but they could not do so due to his resistance to cares so they asked the AP to help. While the AP did hold the resident's hands during the delivery of his cares, this was done because he was trying to swing at her as she provided cares as she asked the two unlicensed caregivers to help her finish the resident's cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed caregivers. The investigation included review of resident records, including assessments, progress notes, incident reports, care plans and facility incident investigation documentation. Also, the investigator observed staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease with early onset and dementia with agitation. The resident's service plan included assistance with incontinence care and bathing. The resident's assessment indicated resident required frequent redirection, was resistive to cares, and needed two staff members to provide care due to physical aggression towards staff members.

The facility internal investigation indicated unlicensed caregiver #1, who was in training with unlicensed caregiver #2, was assisting in providing cares for the resident, however after several attempts, they were unable to complete the cares due to the resident's ongoing resistive behavior. The same document indicated the AP was asked to help provide cares but allegedly was too rough in doing so. The nurse completed an assessment on the resident and identified no injuries. The facility interviewed all three unlicensed caregivers, and although all three gave differing explanations of what occurred.

The same document included interview notes from caregiver #1. She stated they were trying to provide the resident cares as he was incontinent and getting on his clothes and furniture. Unlicensed caregivers #1 and #2 were struggling because the resident was hanging on to his pants and incontinence brief and would not let go. The two unlicensed caregivers asked the AP for help. The resident continued to resist cares, but the AP got him into the bathroom. The AP asked unlicensed caregivers #1 and #2 to help but they were uncomfortable with the situation and avoided helping. Caregiver #1 stated the AP sprayed water in the resident's face.

The same document included interview notes from caregiver #2. The resident was brought to the bathroom to change after incontinent of stool, however the resident was not cooperative and resisted cares, consequently the AP was asked to assist. The AP pulled the resident into the bathroom, restrained his hands, and independently pulled the residents pants down, because unlicensed caregiver #2 declined to assist. The document indicated the AP forced the resident into the shower and attempted to have the resident wash himself, at this time, unlicensed caregiver #2 began to assist washing the resident. When the AP tried to assist with washing, the resident was attempting to strike the AP. Unlicensed caregiver#2 stated the AP sprayed water in the resident's face for attempting to hit or strike the AP. Unlicensed caregiver#2 said she asked the AP to leave and got the resident dressed. The time frame for this event she stated was a ten-minute period.

The same document included interview notes from the AP. She stated she was asked to assist as the resident was uncooperative and had stool all over him. She reported the resident was in the bathroom when she arrived, she asked resident not to punch or yell at them. The resident began squeezing her hands and she let him. She held the resident's hand and unlicensed

caregiver #2 pulled his pants down. Then they cleaned him in the shower, however the resident does not like water, so he was continually moving. The AP denied intentionally spraying water in the resident's face stating she did wash the resident's face and was moving quickly due to resident being uncooperative and resistant to cares.

During an interview, the AP stated she was asked to assist in showering resident. The AP stated she cleaned resident from head-to-toe and did not intentionally spray water in the resident's face. The AP denied forcefully showering the resident or inappropriate behavior. The AP stated she did hold the resident's hands due to history of known aggression to prevent being hit by the resident.

During an interview, a member of the management team that there had not been any concerns with the AP's provision of cares prior to this incident nor since.

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, due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP while the facility conducted an internal investigation.

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
	20291	A. BUILDING: _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

(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
0 000	Initial Comments On August 23, 2023 the Minnesota Department of Health initiated an investigation of complaint #HL202913448C/#HL202917064M. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	