Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL24062003M
Compliance #: HL24062004C

Date Concluded: February 3, 2022

Name, Address, and County of Licensee Investigated:
Presbyterian Homes of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431
Hennepin County

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

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, physically abused a resident when the AP hit the resident on the mouth causing a bruise, grabbed the residents arm causing a bruise and a skin tear, and scratched the resident's neck, causing a bleeding cut.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The resident entered her room (with no injuries) followed by the AP. Sixteen minutes later the AP left the room, and about a minute after that, the resident left the room with bleeding on her lip, neck, and wrist. The resident immediately told a staff member that someone held her against the wall and made her take her pills.

The investigation included interviews with staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and a former employee. The investigator toured the building, observed staff/resident interactions, reviewed video of the hallway outside the resident's room, reviewed the licensee internal investigation,

resident records, personnel files, policies and procedures related to maltreatment of vulnerable adults, and code of conduct. The investigator reviewed photos of the resident's injuries.

The resident lived in the memory care unit of the facility for almost one year and received services that included toileting assistance and medication administration.

An incident report indicated the resident approached a staff one afternoon and was upset someone had pushed her. The staff brought the resident to the office for the nurse to check out. The report indicated the nurse observed the resident bleeding from her lip, neck, and arm. The report indicated the nurse escorted the resident to her room to assess and treat the injuries. The resident had four skin tears (inner right wrist 4 centimeters (cm) long with bruising, left side of neck 1.5 cm long, left forearm 4 cm x 3 cm, top of hand 5 cm x 4 cm), a bruise on the upper lip, and bleeding on her lower lip with swelling. The report indicated the resident said someone pushed her, but later said she fell.

The report indicated the nurse asked the assigned staff (the AP) what happened, and the AP said the resident refused to swallow her Tylenol and tried to chew the tablets. The report indicated the nurse found a half tablet of Tylenol on the floor with blood on it, a full tablet of Tylenol on the floor, and a spilled glass of water on the floor. A follow up report indicated that the nurse thought that the resident may have had fallen.

Video from the hallway outside the resident's room showed the resident entered her room in the early afternoon (at 1:40 p.m.). The AP then entered the room at 1:42 p.m. and remained in the room with the resident until 1:58 p.m. The video showed the resident left the room at 1:59 p.m. (which coincided with the time that the bleeding resident approached the staff.)

During an interview a staff said she observed the resident walking quickly down the hall from her room. The staff said the resident had come out of her room, using her walker, and looked upset. The staff said she saw blood on the resident's mouth, neck, and dripping from her arm onto her walker. The staff asked the resident what happened, and the resident said someone pushed her against the wall and made her take her pills. The staff notified the nurse and handed the resident off to the nurse.

During an interview the nurse said she saw a skin tear on the resident's wrist with bruising, a cut on the resident's neck, and a bloody swollen lip. The nurse said she asked the resident what happened, and the resident said that "someone pushed me into the wall" but later said she fell down. The nurse said she brought the resident back to her room, measured the resident's injuries, and bandaged the areas. The nurse said that she looked around the resident's room for signs of a fall but did not find any. The nurse said she found a broken piece of a Tylenol on the floor with blood on it, as well as another whole Tylenol on the floor.

The nurse said she interviewed the AP, who was working with the resident. The AP told the nurse that she went into the resident's room to give her 2:00 p.m. Tylenol. The AP told the nurse that the resident tried to chew up the pills, but eventually swallowed them.

During an interview a family member said that she called the resident on the day of the incident, while the nurse was in the resident's room bandaging the resident's injuries. The family member said that the resident told her she was bleeding because a staff member attacked her. The resident told the family member that she was scared and did not understand why it happened.

During an interview an administrator said the resident reported that someone held the resident against the wall to give the resident her pills. The administrator reviewed video and observed the AP go into the resident's room (assumed to give the resident Tylenol) and come out 16 minutes later. The administrator said that would be a long time to just give two Tylenol.

During an interview another family member said they took photos of the resident's injuries and they saw a bruise that looked very much like a handprint on the resident's arm.

The AP did not respond to requests for an interview.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, did not respond to requests for an interview

Action taken by facility:

The AP no longer works for the facility.

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

cc:
The Office of Ombudsman for Mental Health and Developmental Disabilities
The Office of Ombudsman for Long-Term Care
Bloomington Police Department
Bloomington City Attorney
Hennepin County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24062	A. BUILDING: _____ B. WING _____	C 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRES HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL24062004C/#HL24062003M On January 21, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 99 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL24062004C/#HL24062003M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On January 21, 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	