

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL255004681M
Compliance #: HL255006006C

Date Concluded: October 7, 2024

Name, Address, and County of Licensee

Investigated:

The Evergreens of Moorhead
502 3rd Avenue South
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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), an unlicensed personnel (ULP), abused the resident when she sprayed the resident with cold water after he attempted to refuse a shower. The AP told the resident, "Your punishment is going to be no breakfast" and sprayed him with cold water a second time. After the shower was over, the AP told the resident, "Don't be stupid."

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. Although the actions of the alleged perpetrator (AP) were inappropriate and unprofessional, it was unable to be determined if the actions of the met the definition of abuse. The resident could not recall the incident and the AP denied abusing the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of resident records, facility internal investigation documentation,

facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed care and services in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and vascular dementia. The resident's service plan included assistance with activities of daily living including bathing, transfers, and medication administration. The resident's assessment indicated the resident had short- and long-term memory impairment and needed frequent reassurance and redirection. The resident had a history of hitting out at staff with cares.

The facility's internal investigation indicated two ULP reported they observed the AP spray the resident with cold water twice and told him he wouldn't get breakfast, when he refused the AP's assistance with a shower.

The facility interviewed the AP about the incident. The AP stated the resident was having a hard time staying awake, was "unusually combative" with his shower, and she was worried he was going to fall. The AP said she turned the water to cold and sprayed his legs and feet to wake him up. The AP said she was told by kitchen staff that breakfast wouldn't be available past 9-9:30 a.m. and because it was taking so long to complete his shower due to his combative behaviors, she told [resident] that he would not be able to get breakfast. The AP said she had no intention of not getting him food, she was just letting him know that the morning's breakfast meal would no longer be available if she couldn't finish his shower in time. The resident was given cookies and a glass of water at 10 a.m. and with lunch time at 11:00 a.m., she did not think getting him a larger meal was necessary.

The facility also interviewed the ULP who reported the incident. One ULP recalled the resident was uncooperative during the shower and the AP seemed frustrated. The ULP observed the AP spray cold water on the resident and the resident "expressed shock" and asked her to stop. The ULP stated that at some point during the shower, she heard [the AP] say to [resident], "Your punishment is going to be no breakfast...Don't be stupid." Another ULP stated the resident was having a hard time staying awake. The ULP stated the AP turned the water temperature to cold and sprayed it on the other ULP's hand saying "see, the water is cold," then sprayed the resident with cold water. The resident put his hands up to try block the water and told her to stop. The AP turned the water back to warm. The resident continued to be physically combative, hitting the AP and she turned the water back to cold and sprayed [resident] with it. The ULP heard the AP tell the resident "As punishment, you're not getting any breakfast. You'll go hungry." After the shower, while the resident was being dressed, the AP was heard saying, "Don't be stupid."

The two ULP who witnessed the incident were interviewed by the investigator. One ULP stated the AP turn the water temperature to cold, asked her to feel it, and asked if it was cold before spraying it on the resident. The ULP stated the resident seemed to be distressed and upset after the cold water was sprayed on him and was yelling for the AP to stop. Another ULP stated the

resident was still sleepy when they tried giving him a shower and the AP sprayed the resident with cold water to wake him up and sprayed him twice. Both ULP stated they heard the AP tell the resident he wouldn't get breakfast if he didn't cooperate. The ULP stated they were uncomfortable with what was happening but were afraid to tell the AP to stop because the AP was intimidating.

During an interview, a facility nurse stated staff immediately notified her of the incident. An investigation was initiated, and the AP was suspended. The facility nurse stated the AP had no previous corrective action but based on their investigation, the AP was terminated for unacceptable conduct.

During an interview, the AP stated she decided to give the resident a shower that morning because he was soaked with urine, and she wanted to get him clean. The AP stated the resident was very sleepy, and she needed help from other staff to get him in the shower because he was so combative. The AP stated the resident was "being difficult to deal with, we put him on the shower chair, and he was sleeping, he's diabetic, he was almost falling.....I asked [other ULP] to open the water so he can wake up, so he doesn't fall, I put a little cold water on his feet and he yelled 'oh my God the water is cold' and that's all that happened." The AP denied telling the resident he couldn't get breakfast and only told him the kitchen was done serving soon and he might miss breakfast.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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 impairment.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility immediately suspended the AP and investigated the incident. The AP was terminated. Facility staff were retrained on resident rights.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25500	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE EVERGREENS OF MOORHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 502 3RD AVENUE SOUTH MOORHEAD, MN 56560
---	---

(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	<p>Initial Comments</p> <p>On September 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL255004681M/#HL255006006C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____