Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL267303603M
Compliance #: HL267304043C

Date Concluded:

Name, Address, and County of Licensee Investigated:
Cannon Falls Assisted Living
900 Main St. W
Cannon Falls, MN 55009
Goodhue County

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

Evaluator's Name: Deb Schillinger RN
Special Investigator

Finding: Substantiated, individual responsibility

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 the AP placed an arm around the resident's neck and a hand over the resident's mouth.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP stated she placed her left arm across placed the resident's chest and placed her right hand over the resident's mouth two or three times to attempt to stop his yelling.

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, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy

and procedures. Also, the investigation included an onsite visit where the investigator observed interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, and mood disturbance. The resident's service plan included assistance of one with mobility and transfers. The resident's assessment indicated the resident was forgetful and needed reorientation at times, was easily understood and was able to walk with assistance of one unlicensed caregiver using gait belt and walker.

A facility internal investigation summary indicated the AP was witnessed by two unlicensed caregivers placing her arm around the resident to talk into his ear and then when the resident would not stop yelling, the AP placed her hand two times over the resident's mouth.

During an interview unlicensed caregiver #1 reported she was helping the AP provide cares to the resident, who was agitated and yelling out. The AP was attempting to talk into the resident's ear to try to calm the resident and did place her hand over the resident's mouth "a couple of times". Unlicensed caregiver #1 stated she was unsure how long the AP's hand was over the resident's mouth but did not feel it was a long time as the resident was attempting to bite the AP's hand. Unlicensed caregiver #1 stated she had worked with the AP for many years and had not witnessed the AP be abusive to residents, however she had noticed the AP had not been herself in the days prior to the incident and felt something may have been affecting her personally.

During an interview, the nurse stated the resident had no physical injury when assessed. The nurse also stated the AP had not had any other reports of resident abuse in the past. The nurse stated during the internal investigation the AP was remorseful and stated she only wanted the resident to stop screaming.

During an interview the AP stated she did place her hand over the residents mouth two to three times for approximately 5-10 seconds. She stated she was trying to get the resident's attention by covering his mouth as he calmed after the first and second time she had placed her hand over his mouth, but the third time he did not. The AP also stated she was not thinking in the moment of the action being right or wrong, but knew it was wrong immediately after the incident. The AP stated she was experiencing health issues recently and the night had been a rough with a number of resident falls. The AP went on to state she and the resident did have a "nice conversation" after incident when the resident had calmed down.

In conclusion, the Minnesota Department of Health determined 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;
(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, resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Facility suspended the AP, completed an internal investigation then terminated the AP.
Retraining on vulnerable adult abuse completed with all facility caregivers.

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.

You may also call 651-201-4200 to receive a copy via mail or email

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 Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Goodhue County Attorney
Cannon Falls City Attorney
Cannon Falls Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST CANNON FALLS, MN 55009

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: #HL267304043C/#HL267303603M On August 8, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 92 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL267304043C/#HL267303603M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	See Public Report for Details	