Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302173140M
Compliance #: HL302173106C

Date Concluded: May 3, 2025

Name, Address, and County of Licensee Investigated:
Arbor Garden Place
535 Canyon Drive Drive NW
Eyota, MN 55934
Olmsted County

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

Evaluator's Name: Julie Serbus, 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) abused the resident when she cut off skin a tag during a hair appointment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While working with the resident the AP, who worked as a licensed cosmetologist, noticed a skin tag that had become mostly detached and causing the resident discomfort. The AP finished removal of the skin tag with a pair of scissors. While the AP should have informed the facility before taking this action to relieve the resident's discomfort and taking it upon herself to remove the skin tag, it is not clear the action met the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The

investigator contacted the AP. The investigation included review of the resident's medical record, assessments, plan of care, service agreement, and the internal investigation. Also, the investigator made a visit to the facility and observed the resident in her memory care unit and assessed the skin on the resident's face and back of her neck.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cognitive impairment and anxiety. The resident's service plan included assistance with showers, dressing, and toileting. The resident's assessment indicated prior to the incident the resident's skin was dry with poor skin turgor and no wounds present. The assessment indicated the resident required escorts to and from locations. The assessment indicated the resident is at risk to be abused and unable to make her own decisions.

The facility provided a designated room within the facility for a licensed cosmetologist to provide services for the residents with a homebound servicer permit which allows a salon operator to offer services at an assisted living facility. The AP worked as a licensed cosmetologist and had an active homebound service permit. Areas of licensure under cosmetology listed under cosmetology included cosmetic care of the hair, skin, and nails on the body surface.

One day the AP was providing cosmetic cares for the resident and the resident was having discomfort due to a skin tag on the back of her neck. During the appointment, the AP removed the skin tag with a pair of scissors.

The progress notes indicated the facility caregivers noticed a small wound on the resident's neck that was bleeding a little and notified the nurse. When the nurse spoke with the AP regarding the removed skin tag the resident's family and medical provider were updated. The facility also monitored the area for any signs of infection. A review of the resident's medical record did not identify any further concerns regarding an infection or complications with healing. The progress note stated the resident had a "minor" complaint of pain.

The medical provider notes indicated the facility updated the medical provider on the day of the incident. The medical provider indicated no further intervention was needed.

During an interview, unlicensed staff member #1 stated residents or their family members can sign up to receive services with the AP. Unlicensed staff member #1 stated the resident was signed up on a weekly basis for a wash and set. Unlicensed staff member #1 stated the resident also received haircuts and perms from the AP as needed. Unlicensed staff member #1 stated the memory care residents are escorted to the beauty shop located in the facility. Staff are then able to leave the resident and when the services are completed return to escort the resident back to the memory care unit.

During an interview, a different unlicensed staff member #2 stated she worked in the memory care unit on the day of the incident. Unlicensed staff member #2 stated the facility staff

member who brought the resident back to the unit the day of the incident, explained to unlicensed staff member #2 the resident had a spot on the back of her neck that was bleeding. Unlicensed staff member #2 stated the AP had stated she cut off a skin tag on the back of the resident's neck. Unlicensed staff member #2 stated the area was no longer bleeding when the resident returned to the unit.

During an interview, a nurse stated she was called down to the memory care unit and told the AP had cut off a skin tag located on the back of the resident's neck. The nurse stated she checked the back of the resident's neck and found 2 small lacerations the size of a fingernail which were open and bleeding. She spoke with the AP who admitted cutting off the skin tag. The nurse stated the AP said she used to get skin tags herself and her medical provider directed her to just cut them off.

During an interview, the AP stated she provides residents at the facility haircuts, perms, hair colors, washes, and weekly sets. The AP stated the resident had a small dry hard spot which stuck out on the back of her neck and caused her pain during weekly hair washes. On the day of the incident the AP placed a towel between the resident's neck and the wash bowl rim to soften the area where the resident's neck rested. The AP stated when resident sat up after washing her hair the towel rubbed the area causing the spot to pull away from the neck skin. So that it was almost completely detached, barely hanging on, and causing the resident discomfort. The AP asked the resident what she would like the AP to do, and the resident stated to cut it off so the used scissors to remove the mostly detached skin tag. The AP stated the area did not bleed, she cleaned the area and reported it to the staff member who came to escort the resident back to her unit.

The facility did not provide photos or diagrams of the resident's skin appearance prior to the incident or immediately after the incident.

During the investigation onsite visit, the investigator observed the resident's face and neck. Those observations included a small area on the back of the resident's neck that appeared to be the area where the skin tag was removed, and it appeared healed.

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

Action taken by facility:
The facility updated the resident's family and medical provider. The facility also monitored the area for infection. The AP no longer offers services at the facility.

Action taken by the Minnesota Department of Health:
No further action required.

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
	30217	A. BUILDING: _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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 April 17, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL302173106C/#HL302173140M. No correction orders are issued.	0 000		