Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302282683M
Compliance #: HL302284516C

Date Concluded: December 22, 2022

Name, Address, and County of Licensee Investigated:
Duluth Heights Lodge
724 Maple Grove Rd
Duluth MN 55811
St Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Carol Moroney RN, Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) emotionally abused a resident when the AP told the resident he was not the resident's slave and stated "I don't wipe your ass."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive.
Information from the facility records, and the interviews could not determine if the AP had repetitive disparaging comments towards residents. The AP denied the allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident's service pan, nursing assessment, the face sheet, the individual abuse prevention plan, and nurses' notes. Also, the investigator observed the resident in the living space.

The resident resided in an assisted living facility. The resident's diagnoses included chronic heart failure, and anxiety disorder. The resident's service plan included assistance with medications and meals. The resident's assessment indicated the resident was independent in activities of daily living, and walking. The resident was confused at times. The resident's individual abuse prevention plan indicated the resident was at risk of maltreatment and not likely able to report abuse.

The facility's internal investigation indicated unlicensed personnel (ULP) stated she answered a call light as the AP did not want to answer it. The ULP stated the resident wanted a pain pill. The resident reported to the ULP, the AP told the resident "I'm not your slave" and "I don't wipe your ass." Other facility staff reported the AP had a bad attitude about working at the facility. The AP's employment was discharged from the facility after the internal investigation was complete.

During the onsite visit, the resident was observed sitting in a chair. The resident was cheerful and reported to like the care at the facility. The resident did not remember any negative event with the staff.

The AP's personnel file included training on dementia management, abuse prevention, professional boundaries, and communication skills. The AP was a certified nursing assistant.

During an interview, the AP stated he did not tell the resident "I'm not your slave and I don't wipe your ass." The AP reported he had a good relationship with the resident. The AP stated only one person was scheduled to work during the night shift at the facility and it was stressful to get all the work done. The AP's employment was terminated following the internal investigation.

During the resident's family interview, the family was aware of the reported concern. The family also reported the resident appeared fearful when telling the incident to the family. The family reported the facility took care of the event and the family was satisfied with the facility's response.

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:

(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: Yes, attempted.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigation the allegation. All the staff were reeducated on vulnerable adult reporting.

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
	30228	A. BUILDING: _____ B. WING _____	C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD DULUTH, MN 55811

(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 On December 6, 2022, the Minnesota Department of Health initiated an investigation of complaint HL302284516C/HL302282683M. No correction orders are issued.	0 000		