DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303429785M
Compliance #: HL303427823C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee Investigated:
Minnesota Greenleaf
1006 Greenwood Street East
Thief River Falls, MN 56701
Pennington County

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

Evaluator's Name: James P. Larson, RN
Special Investigator

Finding: Not Substantiated

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 they grabbed the resident's face and yelled at him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the alleged perpetrator's (AP) actions were inappropriate, there was not a preponderance of evidence to support that the actions of the AP met the definition of abuse.

The investigator conducted interviews with facility administrative staff, unlicensed staff, and contacted a family member of the resident. The investigation included review of the resident's medical records, employee training, internal investigation documentation, incident reports and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder and major depressive disorder. The resident's service plan included assistance with medication management, housekeeping, laundry, and meals.

Facility documentation identified an incident occurred in the common dining area of the facility between the resident and the AP. Documentation indicated the resident interjected for the AP to stop obtaining a blood pressure reading on another resident, because it appeared the procedure was not being done properly. The AP told the resident to "Shut his mouth," then placed her hands on each side of his face and shook it and told the resident to "Shut his damn mouth and mind his own business".

During an interview, facility administrative staff stated the incident involving the AP and the resident was immediately reported, the AP was suspended, and following completion of an internal investigation, the AP's employment was terminated.

During an interview, the resident stated that he was seated across a table from the AP in the dining area while she attended to another resident. It appeared to him that the AP was having difficulty with the automatic blood pressure cuff. After a failed attempt to record a reading, he interjected and told the AP "You got it on wrong." The AP then grabbed his chin and verbally reprimanded him saying, "You stay out of this, it's none of your business".

During an interview, the AP acknowledged that an incident occurred and denied abusing the resident. The AP stated that during this altercation she touched the resident's chin with one hand and said, "Please be quiet", and "Please let me do my job".

During an interview with the resident's family member, they stated that the resident reported that during this altercation, the AP grabbed the resident by the neck and reprimanded him. The family did not recall being notified by the facility about the incident, but had no concerns with the care provided by the facility.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility immediately suspended the AP, completed an internal investigation into the incident and the AP's employment was terminated.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
	30342	A. BUILDING: _____ B. WING _____	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GREENLEAF	1006 GREENWOOD STREET EAST THIEF RIVER FALLS, MN 56701

(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: #HL303428752C On April 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL303428752C. No correction orders are issued. #HL303427823C/#HL303429785M On April 24 and 25, 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 52 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL303427823C/#HL303429785M, tag identification 0620 and 2350.	0 000	Minnesota Department of Health is documenting the State 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.	

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0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	0 620		

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0 620	Continued From page 2 reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report an incident of suspected abuse to the Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include:	0 620		

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0 620	Continued From page 3 R1's diagnoses included generalized anxiety disorder, dependent personality disorder in adult and major depressive disorder. R1's service plan dated June 2, 2021, included assistance with medication management, housekeeping, laundry, and meals. The resident's assessment indicated facility nursing staff sets up weekly medications and that he is able to self-administer his daily medication. During an interview on April 24, 2024, facility administrator (AD)-A stated she was informed by staff members on November 14, 2023, at approximately 8:30 a.m. of an altercation between unlicensed personnel (ULP)-B and a resident (R1) that just occurred in the facility dining area. ULP-B was asked to leave the facility under suspension, while an internal investigation could be done. On November 17, 2024, ULP-B's employment was terminated. Review of complaint documentation indicated the estimated date and time of the altercation between ULP-B and R1 was November 14, 2023. A Minnesota adult abuse reporting center file was not received until November 16, 2023. The licensee's policy titled Abuse Prevention dated January 2024, indicated staff and residents are advised on the Vulnerable Adult Act and what is not tolerable behavior towards others. Complaints will be investigated within 24 hours of receiving any allegations of abuse or neglect from any resident or family member. The policy indicated all staff are provided training on the handling of resident complaints internally as well as the process of facility self-reporting to various agencies, including the MAARC. The policy did not address timing of reporting suspected	0 620		

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0 620	Continued From page 4 maltreatment. The facility's Abuse Reporting (Involving Clients, Independent Residents visitors, and Staff) policy was also requested. This was not provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of one resident (R1) was treated with courtesy and respect when a facility staff member was witnessed verbally reprimanding and grabbing the face of R1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's diagnoses included generalized anxiety	02350		

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02350	Continued From page 5 disorder, dependent personality disorder in adult and major depressive disorder. R1's service plan dated June 2, 2021 included assistance with medication management, housekeeping, laundry, and meals. The resident's assessment indicated facility nursing staff sets up weekly medications and that he is able to self-administer his daily medication. Review of unlicensed personnel, (ULP)-B employee discipline documents indicated that on November 14, 2024, while attending to another resident in the dining area of the facility, R1 interjected for ULP-B to stop attempting to obtain a blood pressure reading because it appeared the procedure was not being done properly. After continuing, R1 again asked ULP-B to stop, and she responded by telling R1 to "Shut his mouth" and then placed her hands on each side of his face and shook it while telling him again to "Shut his damn mouth and mind his own business". During an interview on April 25, 2024, R1 stated after another failed attempt to record a blood pressure reading on another resident, he told ULP-B "you got it on wrong" and then ULP-B grabbed his chin and verbally reprimanded him saying, "You stay out of this, it's none of your business". During an interview on May 16, 2024, ULP-B stated that during this altercation she touched R1's chin with one hand and said, "Please be quiet", and "Please let me do my job". The licensee's policy titled Abuse Prevention, dated January 2024, indicated staff and residents are advised on the Vulnerable Adult Act and what is not tolerable behavior towards others.	02350		

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02350	Continued From page 6 Complaints will be investigated within 24 hours of receiving any allegations of abuse or neglect from any resident or family member. The policy indicated all staff are provided training on the handling of resident complaints internally as well as the process of facility self-reporting to various agencies, including the MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		