Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305562201M
Compliance #: HL305561163C

Date Concluded: August 27, 2024

Name, Address, and County of Licensee Investigated:
Brookdale Winona
835 East Belleview Street
Winona, MN 55987-4502
Winona County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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:
The facility staff abused the resident when the resident sustained bruises on her arms resident's arms during cares.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated.

Facility staff may have caused the resident's bruising during the course of providing incontinence care to the resident who had dementia and began to resist the care. The staff appropriately contacted the nurse for direction but the mode of communication, text messaging, led to a misunderstanding and the direction was not clear on whether to continue after the resident resisted.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions in the facility setting.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure and dementia. The resident's service plan included assistance with activities of daily living including bathing, grooming, toileting, peri-care and changing of incontinence products. The resident used a walker for mobility. The resident's cognitive assessment indicated she was oriented to self only.

A facility investigation record indicated a staff member reported the resident had bruising on her arms and reported it to the manager. Review of photos taken of the resident showed bruising on the top of both the resident's hands.

During an interview, a facility manager stated she started an investigation after she was shown pictures of the bruises the morning following when staff members contacted the on-call nurse for direction after the resident resisted incontinence care. The manger stated the two staff members involved were the only staff members working that evening and there was no one else to send in to complete the resident's care. The two staff members contacted the on-call nurse for guidance, and they did re-approach the resident multiple times to attempt the care. The manager stated the resident could be resistive and did at times hit out at the staff during the incident.

During interview, the on-call nurse stated she went through training with staff earlier that same day on ways to approach the resident to complete cares, as the resident was known to refuse care from some of the younger staff. The nurse stated the two staff members called her and texted her that evening communicating the resident continued to refuse incontinence care after multiple attempts. The nurse stated her message to them was to make attempts to try to change her. The last text sent to her was that resident was "soaked", they got her brief changed but both staff members had scratches on their arms, and that it was "really tough". The nurse stated she interviewed the resident the next day and found the resident was unsettled saying someone had been in her room and wanted her naked.

During interview, one of the staff members who was involved in the incident, said the room smelled of urine and knew the resident needed incontinence care. She approached the resident multiple times, but the resident continued to refuse so she asked the other staff member for assistance. She stated communication with the nurse was via text message and interpreted the texts were to change the resident even if she refused. The staff stated both her and the other staff member were uncomfortable doing that but that is how they interpreted the messages. She stated the resident began to struggle with them as the performed the cares and both caregivers ended up with scratched arms.

During interview, a family member stated she did not remember specifics about the incident but was not alarmed when she was notified. The family member stated the resident could have been bruised from one of her falls or bumping into something.

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: No, due to cognitive loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility reviewed additional training on resident’s refusal for incontinence care and/or toileting. Those interventions for reluctance to accept care were added to the resident’s care plan. The facility added a policy that all communication with the on-call nurse or manager needs to be verbal and not done through text messaging. The APs are no longer employed by the facility.

Action taken by the Minnesota Department of Health:
No 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
	30556	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WINONA	835 EAST BELLEVIEW STREET WINONA, MN 55987

(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 July 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL305561163C/#HL305562201M. No correction orders are issued.	0 000		