Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306363105M
Compliance #: HL306365156C

Date Concluded: July 6, 2023

Name, Address, and County of Licensee Investigated:

Deer Crest Senior Living
470 Hewitt Blvd
Red Wing, MN 55066
Goodhue County

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

Evaluator's Name: Christine Bluhm, 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 the AP yelled at the resident and slapped the resident on the face during toileting care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP denied that she slapped the resident. Although the argument were overheard, no one witnessed the AP slap the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement for the police report. The investigation included a review of policies and procedures, employee personnel files and training records. Several resident medical records were reviewed, including the resident's record.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and history of traumatic brain injury. The resident's service plan indicated the resident was wheelchair bound and required assistance with personal cares and toileting assistance. The resident's assessment indicated she was oriented to person, place and time with intermittent confusion.

Review of the incident investigation summary indicated the AP (an unlicensed staff person) was assisting the resident in the bathroom. Another staff member arrived on the unit, saw the resident's call light was on and heard yelling coming from the resident's bathroom. The staff member entered the resident's room, told the AP to leave and finished providing the resident's cares. At that time, the resident told the staff member the AP had slapped her on her right cheek. Later, the staff member informed facility administrators of the incident and the head nurse made a visit to the facility to interview the resident and staff. The nurse woke the resident who was already asleep in her bed on her right side and noted the resident's cheek was reddened. The head nurse also interviewed the AP, who stated the resident continued to press the call button even after the AP was in the resident's bathroom. The AP also stated the resident had grabbed her clothing during the incident. The AP denied she slapped the resident. Later in the evening, the resident requested assistance and the AP provided assistance again, this time without incident. The resident's cheek was not reddened or had any injuries the following day.

Review of the police report indicated police interviewed all involved in the incident. No charges were filed.

During an interview with the investigator, the staff member stated she overheard an argument between the resident and the AP but did not witness the AP slap the resident.

The resident was interviewed and stated the AP slapped her on the cheek. The resident recalled the events in the same manner as the night the head nurse interviewed her.

During interview with the investigator, the AP stated the resident wanted to go to bed right after supper. The AP stated she was the only staff member in the unit and had to complete supper duties first so she told the resident she would help her as soon as she was able. When she assisted the resident, the resident got aggressive and grabbed the AP's clothing. The AP called for additional help. The AP stated she did not hit the resident.

A family member was also interviewed and stated the resident told them about the incident after it happened.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and provided additional training on reporting abuse. The AP was no longer employed by the facility.

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
	30636	A. BUILDING: _____ B. WING _____	C 06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER CREST SENIOR LIVING	470 HEWITT BOULEVARD RED WING, MN 55066

(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 June 7, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL306365156C/#HL306363105M. No correction orders are issued.	0 000		