Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308012544M
Compliance #: HL308014332C

Date Concluded: June 28, 2023

Name, Address, and County of Licensee Investigated:
Willows & Waters Senior Living
707 Upper Meadow Lane Northwest
Rochester, MN 55901
Olmsted County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive
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 facility financially exploited the resident when the facility refused to return the resident's personal property. In addition, the facility abused the resident when facility staff restrained the resident by locking the resident's wheelchair brakes and applying a lap belt.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. The resident's family confirmed the personal property that was initially withheld, was returned.

The Minnesota Department of Health determined abuse was inconclusive. Facility staff confirmed the resident's brakes were locked at times when the resident was eating. However, it is unknown if the resident had the ability to independently unlock the wheelchair brakes due

to incomplete documentation. Due to conflicting statements provided, it is unable to be determined if a lap belt was used on the resident's wheelchair.

The investigator conducted interviews with facility staff members including nursing staff and unlicensed staff. The investigation included review of Minnesota Department of Health (MDH) survey results, resident medical records, and facility documentation.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, neurocognitive disorder with behavioral disturbance, and congestive heart failure. The resident's service plan included assistance with dressing, grooming, bathing, toileting, transfers, mobility, and eating.

The resident's assessment indicated the resident was resistant to cares and medication administration and had a history of verbal and physical aggression. The assessment also identified the resident was an elopement risk, at risk for falls, forgetful, confused, and had poor decision-making abilities. The assessment indicated the resident required assistance with walking and did not use a wheelchair. The use of a lap belt was not included on the assessment.

Documentation from a staff communication book indicated approximately five weeks after admission, the resident received a new wheelchair. The resident record did not include assessment of the resident's mobility or use of the new wheelchair. Four days after receiving the wheelchair, the resident sat at the edge of the wheelchair, attempted to stand up, and fell. The resident's medical record did not include an incident report related to the fall.

Facility documentation included only four entries in the progress notes during the time the resident resided at the facility. The progress notes did not include information related to the resident's property being withheld, wheelchair brakes being locked, or the use of a wheelchair lap belt.

During an interview, unlicensed personnel (ULP) stated the resident's family was allowed to access the resident's property immediately after the resident discharged, but the family had to request to be let into the garage where it was stored. ULP stated they locked the resident's brakes at the table and if the resident tried to hit or kick at staff. ULP indicated the resident was able to independently unlock the wheelchair brakes but did not remember if the resident's wheelchair had a lap belt.

During an interview, the licensed assisted living director (LALD) stated the resident's property was returned when the family came to get it. The LALD stated the resident's family members were busy and could not pick up the property right away, so it was moved to the garage. The LALD indicated resident property could not be withheld even if a bill was not paid. The LALD stated the resident's progress notes were missing and she was unable to recall specific details about the resident. The LALD stated the resident's wheelchair had a lap belt but told staff they could not use it because it was a restraint. The LALD indicated facility staff locked the resident's

brakes when she was eating but the brakes were unlocked if the resident wanted to leave the meal site. The LALD explained that during the time of the resident's facility stay, many assessments were incomplete and inaccurate. However, the facility was now working with a consultant to ensure accurate assessments and documentation were completed.

The resident's family member was interviewed and stated the resident discharged from the facility but was not admitted to another facility until four weeks later. When the family initially attempted to retrieve the resident's property, they were informed the property would not be returned until the bill was paid. The family member had not received an invoice at that time and was not able to retrieve the resident's property until approximately four or five months later. The family member stated the resident received a new wheelchair during her stay at the facility. The family member said the wheelchair had a lap belt but the facility did not have an order to use the lap belt and considered it a restraint. The family member told facility staff multiple times the resident's wheelchair brakes should not be locked and the lap belt should not be used. The family member indicated during her visits to the facility, she observed many times the resident's wheelchair brakes were locked and the lap belt was in use.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive and financial exploitation 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.

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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means: …
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit
or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

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; Stop here if it is not a restraints issue or sexual abuse.
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None

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
	30801	A. BUILDING: _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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 1, 2023, the Minnesota Department of Health initiated an investigation of complaint # HL308014332C/#HL308012544M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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. THE LETTER IN THE LEFT COLUMN IS	

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0 000	Continued From page 1	0 000	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	