Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312141682M
Compliance #: HL312149258C

Date Concluded: July 31, 2024

Name, Address, and County of Licensee Investigated:
Nagel Assisted Living
232 Elm Street South
Waconia, Minnesota 55387
Carver County

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

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 hit the resident in the face. The resident lost balance and fell to the ground, sustaining injuries to his hands.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. AP-1 was responsible for the maltreatment. AP-1 admitted he hit the resident but stated he did it by mistake. When the resident became aggressive toward AP-1, AP-1 hit the resident in the face with his fist. The resident attempted to hit AP-1 but lost balance and fell backwards onto his buttocks. The Minnesota Department of Health determined AP-2 was not responsible for the maltreatment. AP-2 was not involved with the incident and although AP-2 did not ensure AP-1 received orientation training specific to the resident's needs, AP-2 did not direct AP-1 nor foresee AP-1 would hit the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed for resident behaviors, how staff interacted with residents, and the physical layout of the memory care unit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with behavioral interventions including redirection, reapproach, and to leave the resident alone in safe situations. The resident's assessment indicated the resident's persistent delusions was the resident wanted to go home and thought his family was on the other side of the door to the memory care unit.

An incident report indicated AP-2, a facility nurse, received a call from an unlicensed personnel (ULP) reporting she observed injuries to the resident's hands that were not there earlier in the shift. Injuries included discolored swelling over the base of one of the right fingers, a bruise at the base of the left thumb that extended to his wrist, and a small skin tear on the back of the left hand. The ULP stated AP-1 told her the resident fell onto his buttocks earlier but did not know why he did not report the fall right away. AP-2 instructed the ULP to obtain vitals, apply a cold pack, and obtain more information from AP-1. The next morning, the ULP told AP-2 about AP-1's story changing multiple times. AP-2 assessed the resident's hands and found a new bruise on the left wrist. AP-2 checked the surveillance video, observed AP-1 hit the resident, and called 911 to request an officer.

A law enforcement report indicated law enforcement arrived at the facility the day after the incident. They completed interviews, took pictures, and watched surveillance video. The video showed the resident got up from a chair and started walking towards the door to exit the memory care unit. As AP-1 approached, the resident flipped his walker up towards him. A struggle ensued between the two for the walker. As the resident lifted his right arm and motioned as though he was going to swing at AP-1, AP-1 lifted his arms into a fighting stance. The resident again swung at AP-1 which he blocked. As the resident's arms were in a downward movement, AP-1 closed the distance between them and hit the resident with a right-handed punch, contacting the left side of his face. The resident made a backwards movement and attempted to hit AP-1 but missed. The resident lost balance and fell backwards onto a set of chairs, then onto the floor. AP-1 positioned the walker and helped the resident to his feet. The resident again swung the walker at AP-1, and then the two separated. Law enforcement observed a bruise on the left wrist and swollen knuckles on the right hand. The law enforcement report also included an interview with AP-1. AP-1 admitted to hitting the resident but stated it was a mistake and only raised his hands to deter the resident. AP-1 had been to the facility multiple times and had many interactions with the resident.

AP-1's personnel record indicated he received training on abuse of vulnerable adults and dementia care including behaviors, through the agency he worked with. Facility orientation records lacked orientation to specific needs of the resident to AP-1.

During an interview, a ULP stated AP-1 worked mostly with the resident the evening of the incident because he had been exit-seeking. Towards the end of the shift while helping the resident get ready for bed, the ULP observed injuries to the resident's hands, including swelling and bruises on the top and bottom of his wrists. The ULP asked the resident what happened, and the resident motioned his hands in a punching manner. The ULP asked the resident if he had been in a fight. The resident responded he had. The ULP took pictures, notified AP-2 and sent her the pictures, obtained his vitals, and assisted him to bed as directed. AP-2 instructed the ULP to ask AP-1 what happened while he had been monitoring the resident. The ULP stated AP-1 changed the story of what happened to the resident multiple times. The next morning, the ULP and AP-2 completed an incident report, and the ULP suggested AP-2 watch the surveillance video of the incident because of AP-1 changing his story. AP-2 went to watch the surveillance video, and a short time later, law enforcement arrived.

During an interview, AP-1 stated he had been asked to monitor the resident while another staff member brought some of the memory care residents outside to smoke. The resident tried hitting AP-1 multiple times. At one point, AP-1 grabbed the resident's hands to try to stop the resident from hitting him. AP-1 made hand gestures, putting his fists up, but he did not intend to hit the resident. While attempting to deter the resident, he ended up hitting him. The resident fell onto a couch and slid down onto his buttocks. AP-1 provided the resident's walker and tried to help him up off the ground. The resident continued to try to hit AP-1, but AP-1 instead left the area. AP-1 stated he never received orientation on specific interventions to use when handling the resident's behaviors.

During an interview, AP-2 stated she had been on call when the ULP contacted her about the resident's injuries. The resident fell frequently, and often had bruises from bumping his body. She identified the resident as impulsive with impaired safety and judgement. Because of this and because AP-1 told the ULP the resident fell, AP-2 treated the incident as a fall and responded accordingly. The next day after talking with the ULP more and observing the resident's injuries in person, AP-2 became suspicious and viewed the surveillance video. AP-2 stated she observed AP-1 hit the resident with his fist on the left side of his face. The resident became visibly upset, lost his balance, and fell to the floor. After that, AP-2 called 911 and requested law enforcement. She also notified the agency AP-1 worked for. After the incident, the facility completed training on dementia, vulnerable adult, and de-escalation.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Attempted to interview, but resident was unable.
Family/Responsible Party interviewed: No. Family did not respond to attempts to contact.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
AP-1 did not return to the facility. The facility completed an investigation, called 911 to report the incident, and completed vulnerable adult retraining with staff.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Carver County Attorney
Waconia City Attorney
Waconia Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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: #HL312149258C/#HL312141682M, #HL312142987C/#HL312143060M On June 11, 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 49 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL312149258C/#HL312141682M, tag identification 1480, 2360. No correction orders are issued for #HL312142987C/#HL312143060M.	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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be	01480		

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01480	Continued From page 1 oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to orient one of one unlicensed personnel (ULP)-E to one of one residents (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). The findings include: R1 admitted to the licensee September 11, 2023. R1's diagnoses included dementia. R1's service plan dated June 11, 2024, indicated R1 received assistance with behavioral interventions including redirection, leaving R1 alone if in a safe situation, and removing R1 from the upsetting environment. R1's assessment dated May 8, 2024, identified R1 as disoriented and confused, at risk for elopement, and a high fall risk. ULP-E's staffing agency records indicated he received training on abuse and neglect and challenging behaviors in dementia on August 30, 2023. The licensee-provided orientation binder, undated, included R1's face sheet, R1's provider orders for life sustaining treatment (POLST) and	01480	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 USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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01480	Continued From page 2 blank orientation checklists. The orientation binder did not include R1's service plan, service delivery record, or other information informing agency staff how to provide individualized cares to R1. The licensee's schedule indicated ULP-E worked in the memory care unit on January 23, 2024, from 2:00 p.m. to 10:30 p.m. An incident report dated January 23, 2024, indicated at approximately 9:15 p.m., R1 became frustrated ULP-E blocked the memory care unit door and tried hitting him with his walker and with his hands. ULP-E tried grabbing R1's walker and hands. ULP-E then adopted a "fighter's pose," and as R1 began lowering his fists, ULP-E hit R1 in the face with his fist. R1 began swinging at ULP-E but lost his balance and fell backwards onto his buttocks. R1 sustained swelling and bruising to his hands. During an interview on June 28, 2024, at 2:32 p.m., ULP-E stated he only received a general orientation but did not inform him what needed to be done with every individual resident. ULP-E stated he did not receive orientation to the licensee's policies and procedures, either. ULP-E stated as agency staff, he did not have access to the electronic health records to see what services the residents had and how to work with them. On January 23, 2024, another staff member asked him to monitor R1 while other residents were allowed out of the unit for a smoke. R1 became frustrated and started trying to hit ULP-E. ULP-E stated he inadvertently hit R1 while trying to deter R1 from hitting him. The licensee-provided policy Orientation to Resident, undated, indicated the licensee would	01480	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01480	Continued From page 3 orient each staff person responsible for providing assisted living services to that resident and to the specific services to be provided. This included individualized instructions about the resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	