Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314172820M
Compliance #: HL314172400C

Date Concluded: August 27, 2024

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
202 North Street East
Elmore, MN 56027
Faribault County

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

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 alleged perpetrator (AP) abused the resident when the AP grabbed a cigarette out of the resident's mouth, pulled the resident through the lobby and common area, and then physically forced the resident back into his room, shut the door and walked away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While bringing the resident back in the building from a smoking area, the resident began moving in his chair to prevent entering the building, almost fell out of the chair, and the AP had to reposition him in the chair as he brought him through the doorway.

The resident was not harmed during the incident but became upset. Although the AP had other options to resolve the situation, the incident does not meet criteria for abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures Also, the investigator observed the outdoor smoking area at the facility. The investigator reviewed the facility video of the incident. The police department did not return a request for a police report.

The resident resided in the assisted living facility with diagnoses which included multiple mental health disorder, a history of stroke with residual weakness, and a right arm amputation. The plan indicated the resident required behavior management for physical and verbal aggression, delusions, and agitation. While the resident smoked at the facility, he had a history of not following the smoking guidelines. The resident's assessment indicated he was alert and oriented but could be socially inappropriate and required redirection. At the time of the incident, the resident could move around independently in a specialized Broda type chair.

One day the AP removed the resident from the courtyard area and brought the resident inside the facility after the resident was smoking in the area at the time reserved for the memory care residents. The resident resisted the AP's efforts, became upset and called police after the incident.

The resident's nursing progress notes indicated the resident said the AP did not ask him to come inside the building, but rather the AP grabbed the cigarette out of his mouth and threw it away, reached around the resident's upper body and pulled him into the facility. The same document indicated the AP brought the resident to his room, shut the door, and left him. The resident called 911 and reported the incident.

The facility security video captured the outdoor portion of the incident showed the AP and the resident conversed briefly and the AP looked at his watch twice. The AP then removed the cigarette from the resident's mouth, and the resident turned away attempting to stop him. The AP held the resident in his chair with one hand while trying to open the door with his other hand. The AP appeared to reposition the resident in the chair using both hands as the resident almost slid out of the chair and backed the resident into the building. The video did not include audio.

During interview, the AP stated staff members were directed to clear the courtyard to allow the memory care residents their time for smoke break. The AP stated the resident, who was not a memory care resident, needed to re-enter the facility to allow the other residents access to the courtyard. The AP stated he asked the resident to come in, but the resident did not cooperate. The AP stated he did place reach under the resident's armpits but only to sit him up in his chair. The AP stated he had been instructed by several supervisors to remove the resident's cigarette and bring the resident inside. The AP stated other staff had done the same thing if the resident and that at times the resident did not want to leave when it was time, but this was the process to follow. The AP stated he had heard a message over the radio that the resident needed to

come inside. The AP stated that the memory care residents have only a set amount of smoke time and that becomes a frustration for those residents if they are not allowed their time.

During interview, the house manager stated the resident did at times defy or argue about the smoking schedule to accommodate himself and others. The manager stated she felt it was a difficult situation when the resident flailed himself in the chair like that and it may have been better if the AP had stopped. She stated the AP had other options and could have radioed for more time to clear the courtyard.

During an interview, a nurse stated the resident did at times defy the smoking schedule and at times could be difficult to reason with.

During interview, another nurse stated she completed a physical assessment on the resident after the incident. The resident had no marks and did not appear to be harmed but was upset about coming back into the building. She stated it was typical behavior for this resident who was not memory care, and knew he was not to be in the courtyard area when it was time for the memory care residents to be out there. The resident could have gone to two other areas to smoke at that time. She stated that although she believed the AP had the best of intentions the interaction did not go well.

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, the resident was deceased.
Family/Responsible Party interviewed: No, multiple attempts to contact were made.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation of the incident and reviewed intervention to address the resident's refusals with staff members. The AP no longer worked at 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
	31417	A. BUILDING: _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(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 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL314172400C/#HL314172820M. No correction orders are issued.	0 000		