Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326477809M
Compliance #: HL326474723C

Date Concluded: March 4, 2024

Name, Address, and County of Licensee Investigated:
The Homestead at Rochester
5530 Ballington Rd NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Julie Serbus, 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(s):
Allegation #1: The facility neglected the resident when the resident appeared to be wearing the same incontinent product for several days.

Allegation #2: The facility abused the resident when the resident was found with bruises of unknown origin on her arms.

Investigative Findings and Conclusion:
Allegation #1: The Minnesota Department of Health determined neglect was not substantiated. The facility was not responsible for the maltreatment. While it is true at times the facility does not complete all the resident's planned services, the resident's behaviors due to her disease process at times made providing those cares difficult.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The

investigation included review of medication administration record, plan of care, task list, behavioral documentation, assessments, and progress notes. Also, the investigator observed interactions between staff and the resident during a recent visit to the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included psychotic and mood disturbance, anxiety, and Alzheimer's Disease. The resident's service plan included one to two staff and at times three staff assistance with toileting, showering, and personal hygiene/dressing. The resident's assessment indicated the resident crawled on her knees at times, which caused bruises.

An incident report indicated the resident had the same incontinence product on for several days as an unlicensed caregiver had marked the brief and when she returned a few days later the resident was still in the same brief. The same document indicated that while the brief may in place for multiple days, the resident's skin showed no signs of breakdown.

The resident's service plan indicated the resident at times struck out or kicked at caregivers. The individual abuse protective plan indicated at time the resident was resistant with cares and if/when this occurred caregivers were to leave and reapproach. The same document indicated caregivers should update the nurse as needed.

A review of the resident's medical record indicated that although these interventions were in place, there were period of times when the resident refused cares and the cares were not provided.

During an interview, the unlicensed caregiver stated overnight caregivers got the resident up and toilet her prior to the start of dayshift. The caregiver stated the resident slept a lot both day and night and was incontinent of bladder. While the caregivers offered cares every two and as needed, the resident was often non-compliant and combative, so the nurses were updated as needed.

During an interview, a nurse stated the resident's behaviors included resistance to cares. The nurse stated the facility monitors her skin during weekly baths given by unlicensed caregivers and documented in the medical record. If any skin concerns were identified during these skin checks, the unlicensed caregivers notified the nurse.

During an interview, another nurse stated unlicensed staff brought to the nurse's attention of the resident's very combative during toileting and incontinent cares to include kicking, hitting, pushing staff, and pulling away during cares. This nurse stated the resident's family was aware of and updated regarding the resident's behaviors.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

Allegation #2: The Minnesota Department of Health determined abuse was not substantiated. While the resident did have bruising, it was also true the resident was at high risk for bruising as she often bumped her arms, hands, and/or legs against objects or struck out at caregivers. The facility had interventions in place to minimize these occurrences.

One day the resident had developed bruises on her left forearm raising the concern of possible abuse.

The assessment prior to the report of bruising indicated the resident had a fading bruise located to the left forearm but did not identify other bruising. This same assessment indicated the resident had been combative during cares. During cares or transfer, caregivers avoided grasping the resident's arms or wrists but tried to hold her hand and redirect.

The medical provider progress note indicated the resident's bruising was related to the resident's agitation, which at times occurred during cares. The same document indicated the resident's behaviors kicking and/or grabbing caregivers. The medical provider indicated interventions including medication adjustments had been attempted to address behavioral concerns.

The resident's medication administration record indicated resident was prescribed a preventive daily low dose aspirin (a medication which can cause increased bruising).

The resident's facility record indicated the resident was also on palliative care through a home care provider. The same records indicated palliative care focused on comfort and reflected an awareness of the resident's behaviors during cares.

During an interview, an unlicensed caregiver stated the resident did not like to take showers and strike out at caregiver. The caregiver stated the interventions for the resident included offering cares, but if she refused them to leave and re-approach. If the resident refused more than three times to contact the nurse.

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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

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: Attempt was unsuccessful due to cognitive loss
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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
	32647	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD 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 January 2, 2024 through January 3, 2024,, the Minnesota Department of Health initiated an investigation of complaint #HL326474723C/#HL326477809M, HL#326474716C/HL#326477864M and HL#326473642C/HL#326477146M. No correction orders are issued.	0 000		