Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326477864M
Compliance #: HL326474716C

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: 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 facility abused the resident when the facility caused the resident to develop bruises on their arms and legs.

Investigative Findings and Conclusion:
The Minnesota Department of Health abuse was inconclusive. While the resident did develop bruising, there was insufficient and conflicting evidence to attribute the bruises to abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family and an agency staffing company. The investigation included review of facility progress notes, incident reports, service plan, medications, and tasks reports. During an onsite visit, the investigator made observations of staff assisting the resident with transfers and cares. The observation also included staff interacted with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, mood disturbance, incontinence, and hallucinations. The resident's service plan included hands-on staff assistance for toileting, dressing, walking, transfers, and full assistance with bathing and showering. The assessment indicated the resident exhibited memory loss and confusion.

The facility incident report indicated one day the resident had bruising on her forearms and legs, so a nurse was notified. The nurse found bruises on the resident's hands, forearms, mid-leg and lower leg but how the bruises occurred was unknown.

The facility's internal investigation indicated the staff members were asked for written statements. One unlicensed caregiver said they observed two unlicensed caregivers from an agency pulling the resident by the wrists during cares. However, the same documents indicated it was one of the agency caregivers who initially reported the bruises, and the schedule indicated the other agency caregiver had not worked during the period the bruises developed. The internal investigation did not identify any other causes of the bruises.

The resident's progress note indicated location, size, and color stages of the bruises. The same note indicated the resident refused to allowed completion of the skin assessment and kicked at and pushed the caregiver away.

The resident's medical record indicated the resident did at times swing at, kick at, or push caregivers away. The medical record also indicated the resident had a history of falls.

The resident's medication administration record indicated resident is prescribed a preventive daily low dose aspirin (a medication which can cause bruising to occur more easily).

During an interview, the agency caregiver who reported the bruises stated she identified the bruises during morning cares and asked one of the facility's employees how to report this to a nurse since there was no nurse in the building at the time. The agency caregiver stated she was told to place a note in the facility communication book for the nurse to see the next time she was in the building, which she did along with highlighting it so it would stand out to the nurse.

During an interview, a nurse the resident could be challenging and resistant to cares including striking out at caregivers and kicking.

During an interview, a family member stated they noticed bruising on the resident's forearms and wrists and reported this to the facility's nurses. The family member stated the resident bruised easily and had balance problems which sometimes caused falls. The family member stated they had observed caregivers hold on to the resident's arms near the elbows during transfer but not the lower arm.

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 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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility provided education to unlicensed caregivers to contact a nurse when changes occur such as bruising.

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		