Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338815422M
Compliance #: HL338817540C

Date Concluded: October 30, 2024

Name, Address, and County of Licensee Investigated:
Good Life Assisted Living & ME
5260 127th Street N
Hugo, MN, 55038
Washington County

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

Evaluator's Name: Angela Vatalaro, 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), a staff member, emotionally abused the resident when the AP told the resident she would not assist the resident to walk because the resident took too long, and they did not have enough staff. That same day the resident asked to use the bathroom. The AP said to the resident, you "shit yourself" again and communicated over the walkie talkie to other staff that the resident "shit" herself. The resident was embarrassed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was substantiated. The AP was responsible for the maltreatment. The AP made repeated derogatory and humiliating comments toward the resident in the presence of other residents and staff when the resident required assistance to ambulate and had an incontinent episode.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the AP. The investigation included review of the resident records, facility

internal investigation, facility incident reports, personnel file, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident and observed staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, and anxiety. The resident's service plan included assistance with all activities of daily living, scheduled escorts including assistance with mobility to and from destinations. The resident primarily used a wheelchair for mobility and required assistance with toileting and incontinence care. The resident was able to make her basic needs known to staff but required assistance from others for decision making. The resident was at risk of abuse by others due to the resident's lack of physical and mental capability to protect herself.

Records indicated one day the resident requested to walk from an activities room to the resident's room. The AP said to the resident, "No, you can't walk today; we don't' have staff and you take too long." That same day, the resident told other unlicensed staff she had an urgent need to use the bathroom. The unlicensed staff was assisting another resident and given the resident's urgency, used the walkie talkie to request assistance from the AP. The AP arrived, and in a raised voice in front of other residents, said to the resident "OMG [resident name], you shit yourself, didn't you?" In addition, the AP communicated to other staff using a walkie-talkie stating, "[resident name], shit herself; I'm going to put her in her room." The records indicated the statements caused the resident "considerable embarrassment."

During an interview, unlicensed personnel stated she heard the AP communicate over the walkie talkie that the resident had "shit" herself.

During an interview, the AP stated she received training upon hire on how to communicate with residents. Training included how to talk to residents with respect and not to say anything verbally or mentally bad. The AP said she told the resident she did not have time to help the resident walk and would have time later. The AP said she did not remember if she told the resident the resident took too long for the resident to walk. The AP stated when the resident had an incontinent episode, she made comments towards the resident that the resident had "shit" herself. When the AP made the comments, the resident did not have a response or reaction. The AP also said the comments were heard by others over the walkie talkies. The AP said she made the comments because it was a stressful day, and the AP was stressed out.

During an interview, leadership stated the AP admitted she told the resident they did not have enough staff to walk, and the resident took "too long." Leadership stated the facility did have enough staff and it was an expectation staff were to assist the resident to walk. During an incontinent episode, the AP admitted she said to the resident, the resident had "shit" herself. Leadership stated there were other residents present and all staff with walkie talkies heard the comments. When leadership spoke to the resident, the resident did not remember the incident.

During an interview, a family member stated the resident had incontinent episodes which required staff assistance. The family member stated the resident depended on staff for her care. The family member stated the resident would feel “absolutely mortified” and “embarrassed” if comments were made towards the resident and heard by others that the resident “shit” herself.

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;
(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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility disciplined the AP and provided the AP additional education.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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
Washington County Attorney
Hugo City Attorney
Hugo Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33881	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD LIFE ASSISTED LIVING & ME	5260 127TH STREET NORTH HUGO, MN 55038

(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: #HL338817540C/#HL338815422M On October 1, 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 24 residents receiving services under the Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL338817540C/#HL338815422M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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		