DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350513563M

Compliance #: HL350515879C

Date Concluded: August 16, 2023

Name, Address, and County of Licensee Investigated:
The Lodge
107 Bridgewater Way
Stillwater, MN 55082
Washington County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility and 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) emotionally abused the resident when the AP made a social media post showing a video of the resident sitting in her wheelchair, pulling her pajama dress up. The AP can be heard laughing in the video while saying, "This lady can't walk and she keeps trying to get up, she still wears a diaper."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility and the AP were responsible for the maltreatment. The AP posted a video of herself laughing at the resident on her Snapchat (social media application) account. Several staff members saw the video and reported it to management. The AP was terminated shortly after the incident. The facility failed to ensure the AP was trained on all required content upon hire, including topics related to dementia, vulnerable adult reporting, protecting resident rights, and resident privacy.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of employee records and resident records including progress notes, assessments, and the service plan. Also, the investigator observed cares and medication administration completed by facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's Disease, mild cognitive impairment, and depression. The resident's service plan included assistance with dressing, grooming, bathing, transfers, toileting, and medication administration. The resident's assessment indicated the resident was totally dependent on staff to perform activities of daily living, was forgetful, confused, and had impaired decision making.

An incident report completed by the facility indicated several staff members contacted the clinical nurse supervisor about a video the AP took of the resident and posted to her Snapchat account. The video recorded the resident sitting in her wheelchair, pulling up her pajama dress, and the AP stating, "This lady can't walk and she keeps trying to get up, she still wears a diaper." The AP was heard laughing at the resident and the video ended with the AP laughing. Other staff working with the AP directed her to delete the video and didn't think the AP would post it for others to see. Two days later, the AP met with facility management and admitted to taking and posting the video on Snapchat. The AP was terminated as a result of the incident.

Review of the AP's employee file identified this was her second termination from the facility. Approximately six weeks earlier, the AP was terminated related to concerns with tardiness, taking extended lunch breaks, attendance issues, not answering call pendants, and leaving the locked memory care unit unattended. The AP was rehired two days later. Orientation and training records included no evidence of completion of competency training for delegated nursing tasks or other resident care related skills, and a background check was not completed until nine weeks after the AP was initially hired. Facility management reported the AP had attended a general orientation training session, but did not sign in for the training, so there was no record of her attendance.

During an interview, a ULP stated she was at home when she saw a Snapchat story posted by the AP showing the resident sitting in the common area and the AP laughing. The ULP immediately called the clinical nurse supervisor, and the video was taken down a short time later. The ULP stated the AP had not worked at the facility very long at the time of the incident and was usually "glued to her phone" when working.

Attempts to contact the AP via email and phone were unsuccessful. A subpoena sent to the AP was returned as not deliverable.

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:
(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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Attempts to contact were unsuccessful

Action taken by facility:
The facility immediately investigated the allegation and subsequently terminated the AP. The facility made a timely report to MAARC and retrained staff on resident privacy.

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
Washington County Attorney
Stillwater City Attorney
Stillwater Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35051	A. BUILDING: ______ B. WING ______	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE	**107 BRIDGEWATER WAY STILLWATER, MN 55082**

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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: #HL350516023M/#HL350511300C #HL350513563M/#HL350515879C On July 17, 2023, 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 140 residents, with 78 receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL350516023M/#HL350511300C, tag identification 1760 and 2360. The following correction orders are issued for #HL350513563M/#HL350515879C, tag identification 1300 and 2360.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
01300 SS=F	144G.60 Subd. 2 Qualifications, training, and competency	01300		

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All staff persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs; and promote and be trained to support the assisted living bill of rights.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-A) was trained and competent in the provision of services with current practice standards appropriate to the residents' needs.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients).

Findings include:

ULP-A was hired August 29, 2022, to provide direct care and services to the licensee's residents.

ULP-A's employee record contained a payroll action notice form with an effective date of September 26, 2022, indicating ULP-A resigned and was terminated after she left the locked memory care unit unattended on September 24, 2022, and had ongoing issues with attendance and being tardy over the last seven days. On September 25, 2022, ULP-A was not answering resident pendant calls and was found watching

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01300	Continued From page 2 football in a community room. On that same day, ULP-A took a one hour lunch break that wasn't approved and that ULP-A didn't punch out for. ULP-A was rehired on September 27, 2022. ULP-A's employee record lacked evidence a background study clearance letter was obtained after she was hired on August 29, 2022. NETStudy indicated ULP-A was affiliated to the licensee's roster on August 24, 2022, and supervision was required for the employee. ULP-A's employee record contained a background study clearance letter dated October 13, 2022. ULP-A's online education transcript indicated required dementia training was not completed until October 31, 2022. ULP-A's time card indicated the employee had worked 80 hours by October 3, 2022. ULP-A's employee record contained a payroll action notice with an effective date of November 9, 2022, indicating the employee was terminated for a policy violation. ULP-A's employee record lacked evidence of competency training, 30-day supervision from the registered nurse (RN), and record of orientation. Facility records indicated on November 7, 2022, around 9:00 p.m., several staff members contacted the clinical nurse supervisor after seeing a video posted by ULP-A to her Snapchat stories. The video showed R1 sitting in her wheelchair, pulling her pajama dress up. ULP-A could be heard saying, "This lady can't walk and she keeps trying to get up, she still wears a diaper." ULP-A could be heard laughing at the	01300		

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01300	Continued From page 3 resident and the video ended with ULP-A laughing. ULP-A was brought to the business office on November 9, 2022, where she admitted to taking and posting the video to her Snapchat stories. On July 18, 2023, at 1:03 p.m., licensed assisted living director (LALD)-B confirmed a background clearance letter from August 2022, had not been obtained. LALD-B confirmed ULP-A attended general orientation on August 29, 2022, but since the employee did not sign the attendance sheet, they had no documentation to show she was there. On July 18, 2023, at 1:31 p.m., LALD-B confirmed ULP-A did not have a 30 day supervision or nurse trained competencies in her employee record. No further information was provided. TIME PERIOD TO CORRECTION: Twenty-one (21) days	01300		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure medication was administered as prescribed for one of one residents (R2).

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) 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:

The licensee failed to ensure R2 received his scheduled Bumex (a medication to reduce extra fluid/edema in the body) and missed approximately 56 doses of the medication. The resident suffered an episode of seizure like activity and was treated in the emergency room for fluid overload.

R2's diagnoses included Parkinson's Disease, confusion, type two diabetes, and lymphedema.

R2's service plan, dated September 22, 2022, indicated the resident received assistance with morning and evening cares, medication management, and wrapping and unwrapping dressings to his legs.

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R2's progress notes indicated the resident had seizure like activity on March 26, 2023. Documentation indicated "the resident's eyes rolled back and he started to shake. 911 was called and the resident was taken to the emergency room and returned to the facility the same day."

A progress note from March 29, 2023, indicated "it was discovered that resident was not getting his bumetadine since 3/3/2023." It was determined the pharmacy had the medication entered wrong in the system and it was not sent with the cycle medication refills.

A progress note from April 10, 2023, documented a communication sent to R2's provider to update her on his weight. The note included, "I just wanted to update you on [R2's] weight. Before the medication error with his Bumex, his weight was 251.8 lbs. [pounds] The following is his weight improvement once the PM dose was given again: 3/30/23: 259 lbs, 4/3/23 253.2 lbs, 4/10/23 (today): 251.6 lbs. He his back at baseline in regards to weight!..."

R2's hospital records indicated he arrived in the emergency room on March 26, 2023, around 10:00 p.m. after a syncopal event at the facility. A chest x-ray was completed after wheezing was noted in the resident's lungs. The x-ray showed evidence of pulmonary edema/pulmonary vascular congestion (fluid buildup in the lungs). R2 was given intravenous lasix (a diuretic) for volume overload. Hospital notes indicated the resident's lungs sounded clear after the lasix was administered and "given his chest x-ray findings and edema (swelling), suspect slight volume overload/CHF."

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R2's record contained an order dated January 30, 2023, to increase Bumex to 4 milligrams (mg) by mouth twice daily.

R2's March 2023 Medication Administration Record (MAR) included the following:
-Bumetanide (Bumex) 2 milligram tab, take two tablets by mouth two times a day at 8:00 a.m. and 8:00 p.m.

The March 2023 MAR identified the 8:00 a.m. Bumex dose was given on March 1 and March 2. A note on March 3 indicated from March 4 through March 31, 2023, was marked with an X, indicating the medication was discontinued. The 8:00 p.m. dose was given March 1 and 2 and from March 3 through March 31, 2023, were also marked with an X, indicating the medication was discontinued.

Another entry on the March 2023 MAR for the Bumex was for 2 mg tablet, take two tablets by mouth two times a day between 7:00 a.m. and 10:00 a.m. and between 7:00 p.m. and 10:00 p.m.

The morning dose was documented as effective in the MAR on March 4, 2023.
The March 2023 MAR identified the following morning doses were marked as not given:
March 4
March 8
March 11
March 14
March 15
March 16
March 17
March 18
March 20
March 22

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01760	Continued From page 7 March 24 March 25 March 26 March 27 March 28 The MAR further identified the following morning doses were marked as administered, despite the medication not being available: March 5 March 6 March 7 March 9 March 10 March 12 March 13 March 19 March 21 March 23 March 29 March 30 March 31 The evening dose was documented as effective in the MAR on March 3, 2023. The March 2023 MAR identified the following evening doses were marked as not given: March 4 March 6 March 9 March 10 March 13 March 15 March 18 March 20 March 21 March 23 March 24 The March 2023 MAR also identified the following	01760		

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evening doses were marked as administered, despite the medication not being available:
March 3
March 5
March 7
March 8
March 11
March 12
March 14
March 16
March 17
March 22
March 25
March 26
March 27
March 28
March 29
March 30
March 31

In total, R2 missed 56 doses of Bumex from March 3rd through March 31st.

R2's record contained a medication incident report dated March 27, 2023. The incident report indicated the resident didn't receive his Bumex for this cycle. Therefore, he was not given per MD order since March 3, 2023. The pharmacy was contacted and it was determined he did not get his Bumex due to an error in the system that did not have the medication on reorder every month. Contributing factors were noted to be "failure to follow policy and procedure, frequent distractions, pharmacy dispensing error, training required." The incident report did not identify any other factors to the error or identify a more definitive root cause.

On July 20, 2023, at 2:10 p.m., registered nurse (RN)-B stated they didn't know staff were

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01760	Continued From page 9 documenting the medication as "not available" as they didn't know there was a medication dashboard within their clinical software that would show what medications were held and why. RN-B stated she didn't think staff had reported the medication being out to the former director of nursing. RN-B stated they had received training on their clinical software and after that, it was identified there were several missed doses. RN-B confirmed medication error reports were not completed on the doses that were marked as given while the medication was out, but there should have been, as that would also be a medication error. The licensee's Medication Error policy, dated August 1, 2021, indicated in the event an error occurs, staff would document, track, and resolve medication administration errors for quality improvement. Staff would be retrained if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 2 of 2 residents reviewed (R1, R2) were free from maltreatment. R1 was abused. R2 was neglected.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 10 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment of R2, in connection with incidents which occurred at the facility. The facility and alleged perpetrator (AP) were responsible for the maltreatment of R1, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		