Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356605043M
Compliance #: HL356608604C

Date Concluded: September 27, 2023

Name, Address, and County of Licensee Investigated:
Carver Ridge Senior Living
920 6th Street West
Carver, MN 55315
Carver County

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

Evaluator's Name: Michele Larson, 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) abused a resident when he roughly handled the resident during cares. The AP roughly pulled the resident's right arm to reposition the resident and continued even after the resident told him to stop because he was hurting her. The resident sustained a skin tear and bruises on her right shoulder, arm, wrist, and hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP had a history of similar incidents at other facilities. A family member stated the resident's had excellent memory and was a reliable reporter. Facility video footage showed the AP entered the resident's apartment during the time the resident

stated the incident happened. The resident had several bruises on her right arm and one appeared hand mark like on her shoulder.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident and the AP were interviewed. The investigator interviewed the resident's family member. The investigator reviewed photos of the resident's bruises. The investigation included review of the facility's internal investigation, the resident's record, the AP's staffing agency employee file, review of the AP's past disciplinary actions, including review of an internal investigation from another facility. In addition, the investigator observed resident cares during her onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included arthritis. The resident's service plan included assistance with medication management and personal cares. The resident's assessment indicated she was alert and oriented to person, place, and time and required occasional assistance with transfers.

The resident's progress note indicated at 2:08 p.m., the resident told a nurse the AP entered her apartment at 1:30 a.m. and was "very rough with her," stating he asked her questions but did not wait for her response. The resident indicated she needed assistance with repositioning because of weakness. The resident stated the AP kept pulling on her arm even though she yelled for him to stop because it hurt. The resident complained of a sore right arm. The resident had a hand mark bruise to her right upper shoulder with four small bruises, a bruise to her right upper arm measuring with a skin tear, and a bruise on her right wrist. Video footage was reviewed, and it was determined an agency staff person (AP) entered the resident's apartment during that time frame. The facility requested the AP not return to the facility. The facility filed a vulnerable adult report and the resident's family was notified.

The facility's internal investigation indicated the AP was removed from the facility staff schedule and was not allowed to pick up shifts. The AP's staffing agency was notified of the incident. The AP denied being rough with the resident.

Review of two separate incidents and internal investigations conducted at a previous facility where the AP worked as a permanent staff member, indicated the first incident two unlicensed personnel (ULP) overheard and saw the AP hold a resident's wrist as he slapped the back of his hand to discipline a resident in memory care who dug her nails into the AP's wrist. The AP was disciplined and instructed to never hit his hand or residents' hands as a form of redirection. The second incident occurring several months later and involved a resident who reported the AP hurt him and left bruises on the resident. The facility took the AP off the schedule while an internal investigation was conducted. Approximately 30 minutes later the AP texted the facility stating he quit.

During an interview, a nurse stated she immediately told the nurse manager after the resident told her what happened. The resident told her she told the AP to stop but he kept pulling her

arm. The nurse stated the resident was alert and oriented and said the AP was a strong guy who had not been at the facility that long. The nurse stated after the incident, the facility instructed staff not to grab residents by their arms.

During an interview, the resident stated she screamed in pain when the AP grabbed her arm, stating she told him he hurt her. The resident stated never seen the AP before. The resident stated the AP did not say much and was not a friendly guy stating, “I was afraid.” The resident stated the next morning she told everyone because she did not want the AP around her again.

During an interview, the family member stated she received an early morning phone call from the resident. The resident told her she needed help getting in bed, so she pushed her call button to request assistance. The AP arrived and instructed the resident to sit and lie down on her bed, but the resident stated she was sitting at the foot of the bed and when she laid down, she was too far down from the head of the bed. The family member stated the AP held the top part of the resident’s arm to pull her up in bed. The family member stated the resident told her she was very sore and asked her to please tell the facility she never wanted to see the AP again. The family member stated she was satisfied with how the facility handled the incident, and stated the resident felt safe knowing the AP would never return to the facility.

During an interview, the AP denied he ever worked at the facility, and stated he never had any allegation against him in any facility or agency he previously worked for. The AP stated he worked mainly with staffing agencies, but stated he briefly worked at a facility as a permanent ULP. The AP stated he would “never, never do something like this.”

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 assessed the resident after her report, investigated the incident and the AP was no longer allowed to work at the facility.

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.

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
Carver County Attorney
Carver City Attorney
Carver Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35660	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER RIDGE SENIOR LIVING	920 6TH STREET WEST CARVER, MN 55315

(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: #HL356608604C/#HL356605043M #HL356603705C/HL356607187M On July 20, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL356608604C/#HL356605043M, tag identification 2360. The following correction orders are issued for #HL356603705C/HL356607187M, tag identification 2310, 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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee staff failed to provide walking assistance for one of two residents (R2) with records reviewed. R2 required staff escort assistance with a walker and was a high fall risk. R2 wandered in the hall for 45 minutes without her walker. Several staff observed her alone and failed to provide assistance for safety. R2 fell, hit her head, had bleeding from her head and was in pain. 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: R2's record was reviewed. R2 admitted to the licensee's facility on June 16, 2021. R2's diagnoses included dementia without behavioral disturbance and malnutrition. R2's hospital record indicated on December 7, 2022, R2 fractured two vertebrae after she had an unwitnessed fall inside her apartment. R2's	02310		

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02310	Continued From page 2 family member (FM)-F indicated facility staff did not seemed trained in handling R2's refusal of cares due to her dementia. R2's initial hospice assessment dated April 3, 2023, at 10:00 a.m., indicated R2 was a high fall risk due to impaired functional mobility, unsafe walking, cognitive impairment, polypharmacy, pain, visual impairment, multiple diagnoses, and environmental hazards. Hospice registered nurse (RN)-I observed R2 appeared frail, unsteady on her feet, and required stand-by assistance. Safety measures included assistance with walking. R2 required a two-wheeled walker (2ww) for walking but refused to use it. R2's facility nurse assessment dated April 3, 2023, completed by director of nursing (DON)-C, indicated R2 was medically frail and used a 2ww when she walked. R2 was alert and oriented to self only. R2 had a history of falls. R2 had severe, chronic pain that affected her sleep and day-to-day activities. R2 resided in a locked memory care unit for increased supervision and care. R2 had impaired decision-making due to her dementia, and required cueing and redirection as needed (prn) throughout the day. Staff were to observe and report changes in R2's function and mobility to maintain her safety. Staff were to reapproach, reattempt cares, and ensure R2 was safe when she became resistive. R2's individual abuse prevention plan (IAPP) dated April 3, 2023, completed by DON-C, indicated R2 made poor decisions but was aware of the risks even though DON-C assessed R2 as being unable to retain or follow directions or recall events. R2 was resistive to cares. Staff were to ensure R2 was safe before they briefly left the area to reattempt or tried an alternate staff	02310		

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02310	Continued From page 3 member. R2's service plan dated May 1, 2023, indicated R2 received assistance with personal cares, medication management, behaviors, escorts, meals, laundry, and housekeeping. R2's service delivery record dated May 2023, indicated R2 was to receive staff escort assistance to and from all destinations using her assistive device as required. R2's record indicated between May 16, 2023 and May 17, 2023, R2 had three unwitnessed falls. R2's facility progress note dated May 20, 2023, at 8:00 p.m., indicated R2 had an unwitnessed fall while walking without her two-wheeled walker. Staff found R2 lying face up with blood coming from the back of her head. Review of the licensee's video and audio footage dated May 20, 2023, indicated at 7:00 p.m., R2 walked unsteadily down the hallway without her two-wheeled walker or staff assistance. R2 wore slippers. R2 leaned on her right side as she walked. R2 wandered for 20 minutes then moved out of camera view. At 7:37 p.m., R2 reappeared on video footage. On the same footage, unlicensed personnel (ULP)-L propelled a resident in a wheelchair. Moments later, ULP-L exited the resident's room and walked towards R2 until he was within proximity, then turned and entered another resident's room. ULP-L did not stop to help the resident. At 7:43, ULP-M walked out of a resident's room, then stopped and turned to talk to another ULP. ULP-M saw R2 as she walked unsteadily down the hallway without her walker or staff assistance but did offer any assistance. R2 appeared confused and audibly	02310		

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02310	Continued From page 4 whimpered and moaned. At 7:45 p.m., R2 fell backwards as she reached for the handrail mounted on the wall. The audio sound captured R2's head hit the floor. R2 said "help me, help me." At 7:57 p.m. staff arrived to assist R2 as she laid on the hallway floor moaning. R2 raised her left hand to her head stating, "my head, it's so painful." The facility video footage lacked evidence staff stopped to provide escort assistance or obtain her walker when they saw her wandering alone in the hallway for 45 minutes. In an email dated August 21, 2023, at 9:16 a.m., to DON-C and LPN-H, the investigator requested R2's fall assessment. In an email dated August 21, 2023, at 11:50 a.m., LPN-H sent R2's assessment dated April 3, 2023. LPN-H indicated R2's fall assessment was located on page 11. On page 11, in a section titled "Fall Risk," contained only one question, "Has the resident had any falls in the last three months?" DON-C entered the response "no." R2's fall assessment failed to assess R2's functional status that included her mobility, cognition, gait, strength, balance deficits, or assistive devices to determine her risk of falls. During an interview on August 8, 2023, at 10:30 a.m., DON-C stated R2 was always a fall risk. DON-C stated on May 17, 2023, they discontinued R2's anti-anxiety medication (lorazepam) as a fall intervention after R2 had two falls in one day. During an interview on August 9, 2023, at 10:45 a.m., ULP-E stated staff followed residents'	02310		

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02310	Continued From page 5 service plans to determine what services would be provided to residents. ULP-E stated although R2 was resistive to cares, she never had a problem with R2 stating she would leave and reattempt if R2 refused. ULP-E stated R2 intimidated a lot of the younger ULPs and made them scared of her, stating, "R2 probably wasn't getting the cares she should have on some shifts." During an interview on August 14, 2023, FM-F stated R2 required staff assistance when she walked but did not receive assistance. During an interview dated August 21, 2023, at 10:00 a.m., LPN-H stated escort assistance required a staff member to stay with the resident or remain close by when they walked, stating "in a perfect world somebody should be with them." LPN-H stated they discussed R2's falls and unsteadiness during shift change. LPN-H stated R2 became more unsteady on her feet after each fall. During an interview on August 30, 2023, at 4:30 p.m., hospice nurse LPN-J stated R2 was already a fall risk when she lived in the assisted living side of the facility. During her third interview on September 7, 2023, at 9:46 a.m., DON-C stated it was her expectation staff would be with R2, get her walker if they saw her walking alone, or obtain a wheelchair if she was very unsteady. DON-C stated an intervention they sometimes used was to not have R2's walker in her room because it instigated R2 to want to "get up." DON-C insisted R2's walker was in her room the night she fell, stating R2 did not use it. DON-C stated she expected staff to ensure residents had their assistive devices with	02310		

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02310	Continued From page 6 them, and if R2 appeared unsteady, then staff should have been with her. The licensee policy titled Service Plan, updated April 2023, indicated a service plan meant the written plan between a resident or the resident's designated representative and the home care licensee about the services that would be provided to the resident. TIME PERIOD TO CORRECT: Seven (7) days	02310		
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 two of two resident(s) reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for R1's maltreatment, in connection with incidents which occurred at the facility. In addition, MDH issued a determination maltreatment occurred. The facility was responsible for R2's maltreatement in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	