Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL382922421M
Compliance #: HL382924237C

Date Concluded: January 31, 2023

Name, Address, and County of Licensee Investigated:

Living Hope Homes-Cottage Crest
140 East Spruce Street
South St. Paul, MN
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy L. Boeck, RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
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 the AP grabbed both resident's wrists and dug their fingernails into the skin at the wrist, leaving bruising and small cuts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The resident had bruising on both forearms, the age of which could not be determined at the time of discovery. The facility investigated the report of bruises and injury to the resident with interviews of all staff working in the possible time frame but were unable to determine when the injuries occurred or who was responsible. There were no witnesses, camera footage, or documentary evidence to support the allegation of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a guardian, and former employees. The investigation included review of facility investigations, staffing, incidents,

policies, and procedures related to abuse prevention, incident reporting, unlicensed staff position description, and maltreatment of vulnerable adults. Also, the investigator toured the facility, spoke with residents, and observed staff/resident interactions.

The resident lived in an assisted living facility with diagnoses including Parkinson's Disease. The resident's service plan included assistance with bathing, brace management, compression stockings, grooming, housekeeping, incontinence care, laundry, meals, vital signs, toileting, transfer assistance, and medication administration.

Facility investigation documentation indicated the resident's guardian noticed bruising on the resident's arms during an outing one day, but the resident could not recall what had happened. The staff called the nurse, who responded to the facility.

During an interview, the nurse stated she assessed the resident and noted two large bruises on both forearms with marks in the center that were halfmoon shaped. The nurse stated the injury resembled fingernail marks. The nurse took photos and began an investigation. The nurse stated the resident had a bath with a skin check five days previously, so she interviewed all staff who worked with the resident since that day. The nurse stated she required staff meet with her prior to their next shift.

During investigative interviews, multiple staff members stated they noticed a slight mark on the resident's forearms, but did not see bruising at the time, so they did not feel the need to notify the nurse. The staff stated the nurse provided education to report to the nurse even the slightest of marks on a resident.

During an interview, the resident's representative stated they observed the resident's bruises one day while on an outing, The representative stated they reported to the facility nurse who assessed the resident and immediately made changes to the resident's care plan. The representative stated concerns that staff did not see the marks when they changed the resident's clothing every day. The representative stated the facility has been wonderful, the facility staff cared well for the resident, and whoever did this was a bad seed who needed to be held accountable for their actions.

In conclusion, abuse is 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) 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;
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;

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: An AP was not identified.

Action taken by facility:
The facility conducted an investigation and provided education to staff regarding reporting skin changes.

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
	38292	A. BUILDING: _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES COTTAGE CRES	140 EAST SPRUCE STREET S ST PAUL, MN 55075

(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 12, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL382922375C and #HL382924237C/#HL382922421M. No correction orders are issued.	0 000		