Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL23748001M
Compliance #: HL23748002C

Date Concluded: December 7, 2022

Name, Address, and County of Licensee Investigated:
Bethany Assisted Living
203 N Armstrong Ave
Litchfield, MN 55355
Meeker County

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

Evaluator's Name: Julie Serbus, 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 resident was found to have unexplained bruising and three small crescent shaped cuts on her right upper arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While the resident did have marks on her right upper arm, the cause of those marks remains unknown. The AP denied causing them and there were no other witnesses.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member and the pool agency which employed the AP at the time of the alleged incident. The investigation included review of the facility incident report, the resident's documented progress notes, service plan, individual abuse prevention plan, and the facility's Abuse Prevention Plan. The investigator also observed the facility environment and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with Lewy bodies (a form of dementia which affects problem-solving and reasoning), cognitive impairment and hallucinations (perception of something not present). The resident's service plan included assistance with transfers using a transfer belt and walker, bathing, dressing, grooming, medication management, behavioral management, monitoring for skin conditions, and toileting assistance.

The resident's assessment indicated the resident skin was thin and fragile related to age. The same assessment indicated the resident was unable to give accurate information consistently related to dementia and required reassurance/redirection due to disorientation.

The resident's progress notes indicated an unlicensed personnel (ULP) reported to the registered nurse (RN) of three small marks/cuts found on the resident's right upper arm. The same progress noted indicated the RN cleansed the area and covered the area with one band aid. The resident's progress notes included no further notes made reference to the marks on the resident's arm.

The facility conducted an internal investigation regarding the marks on the resident's arm, which included an incident report and written witness statement forms. The same documents indicated a ULP identified the AP as causing the marks on the resident's arm although the documents also indicated there were no witnesses of the event. The facility interviewed the resident who described a "scuffle" which occurred with an unidentified person. The facility removed the AP from the schedule and contacted the pool agency.

During an interview, the AP stated she worked overnight with the resident, however there was no struggle or incident to cause any injury to the resident's arm as described. The AP stated she was called by the pool agency regarding the discovery of three marks, was not contacted by the facility for an interview.

During an interview, the resident's family stated the resident is extremely hard of hearing and even with the one hearing aid she wears has difficulty hearing. The family member stated the resident has behaviors with receiving cares and can be very stubborn. The family member stated the resident's skin is very frail and bruising and scrapes happened all the time.

During an interview, a representative of the pool agency stated the AP was no longer contracted with the agency.

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) 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, attempted but due to cognition could not proceed
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

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
	23748	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING IN LIT	203 NORTH ARMSTRONG AVENUE LITCHFIELD, MN 55355

(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 Initial comments On September 8, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL23748002C/#HL23748001M. No correction orders are issued.	0 000		