Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362948048M
Compliance #: HL362945129C

Date Concluded: December 5, 2023

Name, Address, and County of Licensee Investigated:

Americare Lodges
20371 Wedigo Park Road
Grand Rapids, MN 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Not Substantiated

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), facility staff, abused a resident when the AP kicked the resident in the butt for not using his walker.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP lightly tapped the resident on the butt with her foot in a joking manner when reminding the resident to use his walker. The resident denied any pain or injury. The allegation does not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the residents case manager and attempted to contact the resident's family member. The investigation included review of AP personnel files, training, and disciplinary actions, resident records including assessments, individualized abuse prevention plan (IAPP), care plan, service agreement, progress notes,

medication administration records (MAR), medication administration notes, behavior plan/documentation, service delivery record, facility investigation documentation, and facility policies and procedures. Also, the investigator observed residents and staff in the facility.

The resident resided in an assisted living facility with diagnoses including schizoaffective disorder, anxiety, depression, paranoia, obsessive compulsive disorder, bipolar disorder, and insomnia.

The resident's medical record indicated the resident had mild cognitive impairment, poor problem-solving skills, and impaired judgment. The resident had poor balance and required reminders to use his walker/cane. The resident could become agitated and verbally aggressive when he was told what to do, and staff were directed to allow the resident space, allow time to calm down, minimize stimulation, and reapproach.

A progress note following the incident indicated the resident denied the AP's actions caused any injury and indicated he was, "embarrassed" and deserved to be treated like an adult.

The facility investigation documentation indicated the resident reported the AP's actions were "light", and he "doubted there was any mark", then said he "just had trouble trusting people".

When interviewed facility staff stated the resident reported he felt like the AP had "treated him like a child", and the incident made him angry. One staff stated the resident reported the AP's actions were done in a joking manner, and indicated the resident had no changes in his mood or behavior after the incident occurred. Another staff stated the resident reported the AP was trying to be playful, but the resident "did not appreciate the AP's actions". The staff stated the resident did not report feeling distressed as a result of the incident.

When interviewed the AP denied any wrongdoing and indicated she jokingly reminded the resident in a lighthearted manner to use his walker, then lifted her foot to the side and barely tapped the resident's buttocks with her foot. The AP stated the resident laughed at the time and did not appear upset or distressed by her actions.

When interviewed the resident stated it was not right the AP treated him like a two-year-old, but he did not know if the AP's actions were abusive, and the AP should have been more professional. The resident stated he maybe felt a little more anxious the day of the incident, but denied the incident caused him distress.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Facility staff immediately reported the concern and removed the AP from her duties pending an investigation. The AP is no longer employed by the facility. The facility provided education to all staff to ensure appropriate professional conduct was provided to residents after the incident.

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
	36294	A. BUILDING: _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE LODGES	20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744

(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 November 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL362948048M/#HL362945129C. No correction orders are issued.	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.	