Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL239864223M, HL239864184M, HL239864203M
Compliance #: HL239867081C, HL239867063C, HL239867146C

Date Concluded: May 8, 2023

Name, Address, and County of Licensee Investigated:
Elderwood of Hinckley
710 Spring Lane
Hinckley, MN 56037
Pine County

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

Evaluator's Name: Carol Moroney 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 facility and alleged perpetrators (AP) 1, 2, 3, 4, 5, 6 abused eight residents when they would swear at them and speak demeaning words to the residents, cause bruises on the residents with their handprints, treating the residents roughly and smoke marijuana in front of the residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. There was no evidence the APs or anyone else in the facility abused the residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's face sheets, service plan, assessments, and progress notes. Also, the investigator observed resident for breakfast and activities of daily living.

The residents resided in an assisted living facility with dementia care unit. All eight residents collectively had diagnoses which included depression, heart disease, and weakness. All eight residents' service plans and assessments demonstrated they required assistance with dressing, activities of daily living, and walking.

During investigative interviews, multiple staff members stated they had not seen any staff swearing at the residents, treating the residents roughly, grabbing residents, leaving bruises on the residents, nor smoking illegal substances.

The medical records for all eight residents were reviewed. No incidents, assessments or notes were found to indicate any unusual activities or roughness with any of the residents' care.

Investigative interviews with resident 2, resident 3, resident 4 and resident 5 all reported good care, and no one was abusive towards them. During observation, no bruises were noted on any of the residents, and they appeared content.

Resident 1's death records indicated the cause of death was hypertensive heart disease and hypertension. Resident 6's death record indicated the cause of death was congestive heart failure. Resident 7's death record indicated the cause of death was natural causes. Resident 8's death record indicated the cause of death was cardiac arrest and septic shock.

During investigative interviews with resident 1 through resident 8's family members, family reported they had not seen any staff mistreating or abusing the residents. The family members were all happy with the care their family member had received.

AP 1, AP 2, AP 3, AP 4, AP 5, and AP 6's employee records were reviewed. All employee records contained required trainings and appropriate verifications.

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 4 of 8 residents who were alive.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action required.

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
	23986	A. BUILDING: _____ B. WING _____	C 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(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 April 26, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL239864223M/ HL239867081C, HL239864184M/HL239867063C and HL239864203M/HL239867146C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.	