Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL258911805M
Compliance #: HL258913437C

Date Concluded: November 23, 2022

Name, Address, and County of Licensee Investigated:
Ely Carefree Living
140 S. 2nd Ave West 113
Ely, MN 55731
St. Louis County

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

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

Finding: Substantiated, individual responsibility

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 the resident when the AP stood over the resident and repeatedly yelled at the resident for several minutes, and then aggressively grabbed the resident's wrists and threatened to break the resident's hands.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Facility staff who witnessed the incident stated the AP lost his temper and stood over the resident and repeatedly yelled at him. The AP aggressively grabbed both of the resident's wrists and threatened to break his hands. An audio recording of the incident was reviewed, and the AP was heard repeatedly yelling and threatening the resident, and acknowledged he scared the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of the resident's medical record including service agreement, progress notes, assessments, facility investigation, and audio recording. In addition, the investigator observed the residents in the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including Dementia with Lewy Bodies, causing behaviors including verbal aggression or outbursts, and poor decision-making skills.

The resident's service plan included assistance with dressing, bathing, toileting, and incontinence care. The resident's assessment indicated he was cognitively impaired with sundowning behaviors (a state of increased confusion, agitation, and irritability occurring late afternoon into the night). The resident would yell out, and staff were instructed to use a calm approach, reminisce with the resident, distract with a 1:1 activity, and encourage the resident to assist with tasks like folding laundry to help keep him busy and reduce sundowning behaviors.

The facility investigation indicated the AP lost his temper on the evening shift and grabbed the resident's wrists in anger and yelled at the resident. The investigation indicated the incident was witnessed by two staff; and the resident was assessed with no injuries noted.

When interviewed staff who witnessed the incident stated the AP was having a "off night" and was told to step away for a break but he refused. The staff stated the AP stood over the resident and began repeatedly yelling at the resident for four to five minutes. The AP aggressively grabbed the resident's wrists in anger and forcefully shook them.

A review of the audio recording of the incident indicated the AP was heard yelling at the resident and stated, "I will shove it so far up your ass!", "I have had enough of you, you hear me, I have had enough!" Staff witnessing the incident were heard repeatedly yelling "stop, stop, stop", and shouting the AP's name telling him to step away from the resident. The AP continued to yell at the resident, "You think your strong, I will break your hands! I am sick of you yelling at people!" The resident was heard responding to the AP, "I am not yelling" in a low tone soft voice, and the AP responded, "No not now, because you are scared!"

When interviewed the AP indicated he had been working long hours and requested not work with the resident because the residents' behaviors were causing him to feel stressed. The AP stated the night of the incident the resident yelled and pointed his finger in the AP's chest. The AP stated he screamed at the resident and grabbed his wrists and threatened to break his hands. The AP stated he was not aware he had lost his temper until he heard another staff screaming his name, then he stopped and left the facility.

In conclusion, 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:
(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, not interviewable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Facility staff intervened to stop the abuse, investigated the incident, and reported to the Minnesota Adult Abuse Reporting Center. Facility staff were educated on abuse and abuse reporting, dealing with difficult behaviors, and caregiver burn out. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.
You may also call 651-201-4890 to receive a copy via mail or email

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
St. Lois County Attorney
Ely City Attorney
Ely Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25891	A. BUILDING: _____ B. WING _____	C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELY CAREFREE LIVING	140 SOUTH 2ND AVENUE WEST ELY, MN 55731

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 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: On November 2, 2022, the Minnesota Department of Health conducted a complaint investigation for HL258911805M, HL258913437C at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 41 residents receiving services under the provider's Assisted Living Dementia Care license. The following correction orders were issued for HL258911805M, HL258913437C, tag identification 2360.	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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On November 2, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and an individual staff member was responsible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	