DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL281148345M
Compliance #: HL281145532C

Date Concluded: December 13, 2023

Name, Address, and County of Licensee Investigated:
Cherrywood Advanced Living
171 Henry Rd. 145
Big Lake, MN 55309
Sherburne County

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

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

Finding: Substantiated, facility and individual responsibility

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 resident was abused when the alleged perpetrator, (AP), facility staff, shoved a t-shirt into the resident's mouth to quiet him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP entered the resident's room to listen to lung sounds and the resident yelled for the AP to leave the room. The AP shoved a shirt into the resident's mouth to quiet the resident and attempt to listen to lung sounds.

In addition, the Minnesota Department of Health determined neglect was substantiated. The facility was responsible for maltreatment. The facility had knowledge the AP had prior allegations of potentially abusive conduct toward residents, however, the facility failed to follow up on the concerns to ensure the residents safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family and law enforcement. The investigation included a review of resident records including face sheet, service/care plan, assessments, individualized abuse prevention plan (IAPP), progress notes, vital signs, medication and treatment administration records, medication administration notes, incident report, facility investigation documentation, facility policies/procedures, facility email communication, AP personnel files including training, grievances/complaints/conduct concerns, background study, termination notice, and nursing license.

The resident resided in an assisted living facility with dementia care with diagnoses including hereditary ataxia (a nervous system disease affecting the central nervous system), peripheral vascular disease (narrowing of the blood vessels), persistent asthma, and weakness.

The resident's service/care plan indicated the resident was totally dependent on two staff for assistance with bed mobility, eating, toileting, dressing, personal hygiene, and used a full body Hoyer mechanical lift for transfers. The service/care plan identified the resident had difficult to understand speech and would yell if he became frustrated. The care plan instructed staff to mute the resident's television and ask the resident to speak slowly.

The resident's assessment indicated the resident was only able to make slight movements of his extremities. The resident was able to respond to verbal commands but could not always communicate his needs due to a speech impairment. Staff were to listen closely, ask the resident to repeat himself if necessary, and provide distraction and redirection using a reassuring voice and touch.

The resident's individual abuse prevention plan (IAPP) indicated the resident was susceptible to abuse and unable to identify or remove himself from potentially dangerous situations. The IAPP indicated during times of frustration the resident may swear or call staff names. Staff were directed to redirect the resident, explain to the resident in a way he will understand, remove themselves from the situation, and to report suspected abuse toward the resident.

The facility investigation included a typed witness statement from the manager which indicated one day the resident felt feverish, so staff called for the AP to assess the resident. The staff removed the resident's long sleeved thermal shirt and grabbed a white t-shirt to change the resident into, then the AP entered the room. When the resident saw the AP, he yelled "Get out of here, get out of here!" The AP walked up to the resident and said, "STOP yelling, I need to listen to your lungs!", but the resident continued to yell. The AP picked up the resident's t-shirt with her right hand and pushed it into the resident's mouth. The statement indicated the manager hit the AP's hand and shirt away from the resident's mouth and said, "What are you doing?", the AP responded, "I can't hear his lungs when he is yelling!" The manager instructed the AP to leave the resident's room, but the AP refused to leave and continued to listen to the resident's lungs. The statement indicated the manager reported the incident to nursing leadership the following morning.

The facility investigation documentation included statements from nursing leadership. One statement indicated the nurse was notified of the incident, then the following day he talked to the AP. The statement indicated the AP did not deny putting the resident's t-shirt into the resident's mouth, but indicated the AP had not attempted to suppress the resident's breathing or speech and her actions were intended in a lighthearted gesture. The statement indicated the AP apologized and returned to her duties.

Internal email communications to facility leadership indicated the manager had reported the AP's potentially abusive conduct toward residents to nursing leadership prior to the incident. One reported incident indicated the AP was heard saying to a resident "You move so slow flies are landing on you." Another incident indicated the AP asked a cognitively impaired resident (who was a math teacher), "Ok math teacher, what is two plus two?" When the resident responded incorrectly the AP stated, "Some math teacher you are!" The emails indicated each time concerns were reported to nursing leadership, excuses were made for the AP's conduct, and no follow up was completed.
After the manager witnessed and reported the witnessed abuse of the AP shoving the t-shirt into the resident's mouth, nursing leadership again excused the AP's conduct, and the AP resumed her normal job duties with no action taken.

When interviewed the resident indicated he remembered the AP and the incident. The resident indicated the AP shoved the t-shirt into his mouth the day of the incident. The resident indicated the incident made him feel bad and it was hard for him to breathe. The resident became emotional with recollection of the incident.

When interviewed the manager stated the AP had conduct concerns with residents prior to the incident. The day of the incident the manager stated the resident appeared afraid of the AP and began yelling for her to get out. The manager stated the AP approached the resident, told him to be quiet, and then suddenly grabbed the resident's t-shirt with her right hand, and forcefully pushed it into the resident's mouth. The manager stated she was shocked by the AP's actions and hit the AP's hand and the shirt away from the resident's mouth. The AP stated, "Well I cannot hear if he is hollering!" The manager stated the incident was disturbing and the resident was not able to remove the t-shirt from his mouth due to mobility impairment. The manager stated the AP's actions were not done in a playful, joking manner.

When interviewed another staff witness stated when the AP entered the resident's room the resident immediately yelled at the AP, "Get away, don't touch me". The witness stated it was unusual for the resident to yell at staff in that way. The witness indicated she went to get medication for the resident at the counter with her back turned and did not see the AP's actions, but heard the manager say, "What are you doing, that is so inappropriate!" The witness stated the AP said something like "I am trying to hear his lung sounds but he is yelling!" The witness indicated the AP was not joking, and her actions and responses did not sound like they were done in a lighthearted manner. The witness stated when she turned around the resident

appeared upset, was swinging his arms, and yelling at the AP, “Get out of here!” The witness stated she reported concerns to leadership in the past regarding how the AP treated residents. One night the AP brought a resident out to the common area and left him there alone isolating him. The resident sat there hollering, “hello, hello” all alone by himself.

When interviewed, nurse leadership staff indicated the AP had a joking sarcastic personality and was verbally corrected in the past for unprofessional behavior. However, the employee had no formal coaching or conduct concerns documented prior to the incident.

When interviewed another leadership staff denied being aware the AP had conduct concerns with residents prior to the incident. The nurse stated he was not aware of the incident until five days after it occurred, at which time the AP was removed from providing care to residents.

The AP’s personnel files lacked documentation of any reported concerns or subsequent actions taken to prevent recurrence of resident maltreatment and ensure resident safety.

A police report indicated when an officer interviewed the resident, he recalled the incident and confirmed the AP put his shirt into his mouth, and stated it made it harder for him to breathe. The police report indicated witnesses heard and saw the incident occur. When interviewed by the officer the AP denied shoving the resident’s t-shirt into his mouth and stated she fluttered the shirt across the resident’s face and told him to hush while motioning her hand back and forth. The AP denied any other staff said anything to her at the time of the incident. The police report indicated the AP was asked if putting a shirt in someone’s mouth to silence them was medical practice and the AP stated it was not.

The investigator attempted to contact the AP via phone, email, and subpoena. The AP refused to respond to interview attempts.

In conclusion, the Minnesota Department of Health determined neglect and abuse were 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: The AP refused to respond to interview attempts including telephone, email, and subpoena.

Action taken by facility:
The housing manager reported the incident, several days later the resident was assessed for injuries, statements from the housing manager and nursing leadership were obtained, then five days after the incident occurred the facility reported the abuse to MAARC. 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 651-201-4200 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
Sherburne County Attorney
Big Lake City Attorney
Big Lake Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL281148345M/ #HL281145532C On November 8, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 16 residents receiving services under the provider's Assisted Living with Dementia Care license. The following order is issued for #HL281148345M/#HL281145532C, tag identification 0620, and 2360.	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.	
0 620 SS=I	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	0 620		

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0 620	Continued From page 2 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to immediately report observed abuse for 1 of 1 resident, R1, reviewed for allegations of staff mistreatment. Staff observed licensed practical nurse (LPN)-A shove a t-shirt into R1's mouth to make him be quiet. Staff failed to immediately report the abuse until the following day. After the incident was reported the licensee failed to thoroughly investigate the incident or take action to protect residents. The incident was not reported to the common entry point Minnesota Adult Abuse Reporting Center (MAARC) until five days later. The staff had prior concerns regarding LPN-A's mistreatment of residents, however, the facility failed to report or investigate the allegations. This had the potential to cause harm to all 16 residents residing in the facility when LPN-A continued to have access to residents after an incident of witnessed abuse occurred.	0 620		

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0 620	Continued From page 3 This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: R1 was admitted to the assisted living with dementia care facility on March 21, 2022, with diagnoses including hereditary ataxia (a nervous system disease affecting the central nervous system), peripheral vascular disease (narrowing of the blood vessels), persistent asthma, and weakness. R1's service/care plan dated May 29, 2023, indicated R1 was totally dependent on two staff for assistance with bed mobility, eating, toileting, dressing, personal hygiene, and used a full body Hoyer mechanical lift for transfers due to limited mobility. The care/service plan identified R1 had difficult to understand speech and would yell if he became frustrated. The care plan instructed staff to mute the resident's television and ask the resident to speak slowly. R1's Braden scale assessment dated February 27, 2023, indicated R1 had very limited mobility and was only able to make slight movements of his extremities and could only sit for a short period of time. R1's significant change assessment dated August 28, 2023, indicated R1 was able to respond to	0 620		

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0 620	Continued From page 4 verbal commands but could not always communicate his needs due to speech impairment. Staff were to listen closely, ask the resident to repeat himself if necessary, and provide distraction and redirection using a reassuring voice/touch. R1's individualized abuse prevention plan (IAPP) identified R1 was susceptible to abuse and unable to identify or remove himself from potentially dangerous situations. The IAPP indicated during times of frustration R1 may swear or call staff names. The IAPP instructed staff to redirect R1, explain in a way R1 would understand, remove themselves from the situation, and directed staff to report suspected abuse toward R1. The licensee provided internal investigation documentation which included the following statements: - A undated signed witness statements from housing manager (HM)-B who documented one day she heard R1 call out, so HM-B entered R1's room. R1 indicated he was wet and needed to be changed, so HM-B called unlicensed personnel (ULP)-C to help transfer the resident into his bed. During the process of getting R1 to bed the staff noted R1 felt feverish and called for LPN-A to assess R1. The statement indicated the staff removed R1's long sleeved thermal shirt and grabbed a white t-shirt to change the resident into, then LPN-A entered the room. The statement indicated when the resident saw LPN-A he yelled "get out of here, get out of here!" LPN-A walked up to the resident and said, "STOP yelling, I need to listen to your lungs!", but the resident continued to yell. Then LPN-A was observed to pick up R1's t-shirt with her right	0 620		

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0 620	Continued From page 5 hand and shove it into the resident's mouth to make him be quiet. The statement indicated HM-B hit the LPN-A's hand and shirt away from the resident's mouth and said, "What are you doing?", and LPN-A responded, "I can't hear his lungs when he is yelling!" Then, the HM-B instructed LPN-A to leave the resident's room, but LPN-A refused to leave and continued to listen to the resident's lungs, then left R1's room. The statement indicated another staff present at the time of the incident asked HM-B "Why did you tell LPN-A to leave?" and HM-B told ULP-C what she had witnessed. The statement indicated HM-B reported the incident to licensed practical nurse care coordinator (LPNCC)-D the following morning. - Another typed statement signed and dated September 6, 2023, by registered nurse clinical manager (RNCM)-E three days after the incident occurred indicated he was notified that HM-B had witnessed LPN-A ball up R1's t-shirt and put it into his mouth due to him yelling so she could assess his lung sounds. The statement indicated R1 was assessed for injuries several days later with none noted. - Another typed statement signed and dated September 13, 2023, indicated LPNCC-D was notified of the incident, then talked to LPN-A the following day who did not deny putting R1's t-shirt into his mouth. The statement indicated LPN-A had not attempted to suppress R1's breathing or speech and her actions were intended in a lighthearted gesture. The statement indicated LPN-A apologized then returned to her duties with no other actions taken. The licensee investigation documentation lacked information for a thorough investigation of the	0 620		

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0 620	Continued From page 6 incident including documentation of the interview completed with LPN-A and LPNCC-D, a statement from LPN-A following the incident, or action taken to prevent recurrence including suspension pending an investigation, disciplinary action, coaching, or education. The documentation provided indicated R1 was not assessed for injuries timely or interviewed about the incident. The investigation documentation indicated no interview/statement was obtained from ULP-C who was a witness to the incident, and in the room at the time. On September 8, 2023, at 10:50 a.m. a facility email correspondence from the HM-B to the licensed assisted living director (LALD)-F indicated HM-B had reported LPN-A's potentially abusive conduct toward residents to nursing leadership many times prior to the incident with no action taken. One incident indicated LPN-A was heard tell a resident "You move so slow flies are landing on you", another incident LPN-A was heard asking a resident who was a prior math teacher suffering from cognitive impairment "Ok math teacher, what is two plus two?" when the resident responded incorrectly LPN-A responded, "Some math teacher you are!" The emails indicated each time LPNCC-D and RNCM- E made excuses for LPN-A's behavior or doubted the reports, and nothing happened. The email communication indicated due to concerns reported by multiple staff and witnessed/heard by HM-B, HM-B stayed into the evening shifts to supervise LPN-A. Then, after HM-B witnessed and reported LPN-A had abused R1 when she shoved R1's t-shirt into his mouth to make him be quiet, nursing leadership again made excuses for LPN-A's conduct, and she was allowed to resume her duties with no action taken. The emails indicated due to lack of action taken by nursing	0 620		

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0 620	Continued From page 7	0 620		

leadership LPNCC-D and RNCM-E, HM-B continued to report her concern and reported the incident to LALD-F five days after the incident occurred who then took action to ensure resident safety and directed staff to report the incident to MAARC.

On September 9, 2023, at 6:48 p.m. a facility email correspondence from HM-B to the facility owner indicated HM-B and two other staff had reported concerns with LPN-A's conduct many times to LPNCC-D and RNCM-E prior to the incident with R1, and each time excuses were made, or they doubted the reports. The email indicated when she spoke to RNCM-E about the incident he indicated he would give LPN-A a written warning, and indicated HM-B continued to report the incident to LALD-F and the owner because no action was taken by LPNCC-D or RNCM-E when the incident was reported.

Facility documentation of the AP's complaints, grievances, conduct concerns, and coaching were requested, and the AP's personnel files reviewed with no documentation of concerns prior or subsequent actions or coaching noted.

A review of LPN-C's time clock punches indicated on the day of the incident she continued to work on September 3, 2023, until the end of her shift and punched out at 10:28 p.m. On September 4, 2023, LPN-A worked 2:06 p.m. until 10:30 p.m. On September 6, 2023, LPN-A worked 2:03 p.m. until 10:30 p.m. On September 7, 2023, LPN-C worked 1:59 p.m. until 10:27 p.m. indicating she continued to have access to R1 and other residents after the incident of abuse toward R1 was reported.

A termination notice dated September 8, 2023,

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(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
0 620	Continued From page 8 indicated LPN-A placed a t-shirt into a resident's mouth to make him be quiet. LPN-A stated she was just playing around, and it was not her intent to do any harm to the resident. The termination notice indicated a MAARC to the common entry point was filed. A common entry report MAARC report incident #136849894, indicated the incident occurred on September 3, 2023, at 5:30 p.m. and the report was submitted by the facility reporter on September 8, 2023, at 6:00 p.m. five days after the incident occurred. A police report dated September 11, 2023, indicated when interviewed the resident recalled the incident, and confirmed LPN-A put his shirt into his mouth, and stated it made it harder for him to breathe. The police report indicated the officer interviewed the housing manager and staff witness who confirmed they witnessed and heard the incident occur. On November 8, 2023, at 11:37 a.m. LPNCC-D stated LPN-A had a joking sarcastic personality and was verbally corrected in the past for unprofessional behavior but had no formal coaching or conduct concerns toward residents that he was aware of prior to the incident with R1. LPNCC-D stated suspected maltreatment should be reported immediately and to MAARC within 24 hours. On November 8, 2023, at 1:02 p.m. RNCM-E denied being aware LPN-A had conduct concerns with residents prior to the incident with R1. RNCM-E stated he was not aware of the incident until five days after it occurred, then took action to remove LPN-A from providing care to resident's and reported the incident to MAARC. However,	0 620		

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	28114	A. BUILDING: _____ B. WING _____	C 11/08/2023

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0 620	Continued From page 9 RNCM-Es signed and dated statement indicated he was aware of the incident two days prior but took no action to ensure the safety of the residents. RNCM-E stated when he talked to LPN-C she indicated she was just playing around and denied putting R1's shirt into his mouth but R1 was yelling, and she tried to quiet him to assess his lung sounds. RNCM-E indicated it was determined the incident occurred and LPN-A was no longer employed by the facility as a result of the incident with R1. On September 8, 2023, at 12:01 p.m. HM-B stated LPN-C had potentially abusive conduct concerns with residents prior to the incident with R1 and made degrading comments to residents to make them feel bad. HM-B stated the day of the incident, R1 appeared afraid when LPN-A entered the room and began repeatedly yelling for her to get out. HM-B stated what she heard from R1 was different from his normal yelling behavior. HM-B stated LPN-A approached the resident told him "Be quite" then instantly grabbed R1's t-shirt with her right hand and abruptly and forcefully shoved it into R1's mouth. HM-B stated she was shocked by LPN-A's actions and hit LPN-A's hand and R1's shirt away from his mouth and said "What are you doing!" LPN-A responded, "Well I cannot hear if he is hollering!" HM-B stated LPN-A did not talk to R1 or explain what she was going to do, she just grabbed R1's t-shirt and pushed it into R1's mouth to silence him. HM-B stated the AP's actions were so instantaneous, it seemed like an instinctive routine response. HM-B stated the resident did not appear surprised by LPN-A's actions, like LPN-A had done that to make him be quiet before. HM-B stated LPN-A had no empathy, and her actions were in no way funny, nor were they done in a playful manner. HM-B stated the	0 620		

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0 620	Continued From page 10	0 620		

incident was disturbing and still woke her up at night. HM-B stated R1 was unable to protect himself or remove the t-shirt from his mouth due to mobility impairment.

On November 8, 2023, at 12:39 p.m. ULP-C stated she was present in the room when the incident occurred with LPN-A and R1. ULP-C stated when LPN-A entered R1's room to assess him, R1 immediately hollered "Get away, don't touch me!" ULP-C stated it was unusual for R1 to yell at staff in that way and indicated R1's reaction to LPN-A was different then it was with other staff. ULP-C stated she was at R1's medication counter in R1's room with her back turned and did not see LPN-A push R1's shirt into his mouth, but heard the HM-B say "What are you doing, that is so inappropriate!", and LPN-A responded by saying something like "I am trying to hear his lung sounds and he is yelling!" ULP-C stated LPN-A did not sound like she was joking, or her actions were done in a lighthearted manner but rather she was justifying her actions or making excuses for her behavior. ULP-C stated when she turned around R1 appeared upset, was swinging his arms, and yelling at LPN-A "Get out of here!" ULP-C stated she did not hear LPN-A redirect R1, comfort R1, or explain to R1 what she needed to do. ULP-C stated LPN-A had made rude comments toward residents in the past and treated them like a chore not a human being. ULP-C described an incident when LPN-A brought a resident out to the common area at night and left him there alone isolating him, and the resident sat there hollering "hello, hello" all alone by himself. ULP-C stated she had observed LPN-A feeding residents during meals and indicated she did not take time when feeding residents or give smaller bites, but instead shoveled food into their mouth and let it fall out all

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0 620	Continued From page 11 over the resident. ULP-C stated she had reported her concerns to HM-B and LPNCC-D prior to the incident with R1. ULP-C indicated she did not report the incident with R1 because she thought HM-B had. On November 8, 2023, at 1:49 p.m. R1 indicated he remembered LPN-A and the incident by responding to yes and no questions. R1 was asked if LPN-A pushed his t-shirt into his mouth the day of the incident, and R1 nodded his head yes and said "Yes." R1 was observed trying to pull his shirt and blanket up to his mouth to show the investigator what happened. R1 stated the incident made him "feel bad" and indicated he did not know if the LPN-A would hurt him. R1 indicated the HM-B stopped LPN-A and "kept him safe" at the time of the incident. R1 indicated it was hard for him to breath, and indicated HM-B stopped the AP and "kept him safe" then became emotional with recollection of the incident. On November 14, 2023, at 11:15 a.m. LALD-F stated R1 was frail and unable to defend himself. LALD-F stated R1 had speech impairments but was able to answer simple yes and no questions accurately and was a reliable reporter. LALD-F stated she became aware of the incident September 8, 2023, when HM-B called her and reported the incident because nothing was being done after the incident was reported to LPNCC-D and RNCM-E. LALD-F stated the resident was not interviewed or asked about the incident, and indicated ULP-C was also not interviewed who was a witness to the incident. LALD-F stated no investigation was done when the incident was witnessed and reported by a manager of the facility, and indicated if HM-B had not persistently reported the incident nothing would have been done. LALD-F stated LPNCC-D and RNCM-E	0 620		

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0 620	Continued From page 12 took no action to protect the residents in the facility and stated LPN-A should have been immediately relieved of her duties, and not allowed to return to the facility, the incident should have immediately been reported, and an internal investigation of the incident including interviews with all potential witnesses should have been done. LALD-F stated a statement from LPN-A should have been obtained, and an interview and assessment of R1 should have been done right away. LALD-F stated LPN-A abused R1 when she balled up a t-shirt and put it into R1's mouth, and stated the incident made her question why nothing was done to protect the health and safety of the residents. LALD-F stated no re-education for facility staff on reporting concerns complaint/grievances process, or identifying/reporting potential maltreatment was completed after the incident with R1 occurred when concerns were identified. LALD-F stated she provided education to HM-B on the reporting process. A facility policy titled "Complaint/Grievance" dated August 1, 2021, indicated the purpose was to ensure complaints were resolved in a timely and appropriate manner for employees and residents who have complaints or concerns. The procedure indicated a complaint form should be filled out by the resident, employee, or employee representative and given to the supervisor of the department or the LALD. If a resident, resident representative, or employee is unable to fill out the form one will be completed on their behalf by the supervisor or LALD. Section 4. indicated if needed an investigation surrounding the facts would be initiated. Section 5. indicated during the investigation process, when possible, the resident, resident representative, and employees would be asked to participate in determining a	0 620		

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0 620	Continued From page 13	0 620		

solution and resolution of the complaint. Section 6. indicated after the investigation was completed an explanation and action taken in response to the complaint would be provided. Section 7. indicated in a case where maltreatment was identified (abuse, neglect, or exploitation), a staff member would promptly contact MAARC to make a report.

The facility document titled "Record of Grievance/Complaint" included information on who made the complaint, the date, information on what the complaint was regarding, who investigated the concern, how the complaint was investigated, when the investigation was completed, what the findings of the investigation were, actions taken to correct or address any issues or problems, and the response provided to the originating complaint with a section to sign and date by the registered nurse responsible party. The facility documentation provided failed to indicate the facility utilized or enforced their complaint/grievance/investigation process. No documentation of complaints/grievances regarding reported conduct concerns with LPN-A and residents prior to and including the incident with R1 was provided when requested.

A facility policy titled "Vulnerable Adult Maltreatment -Preventions and Reporting" dated August 1, 2023, indicated maltreatment of vulnerable adults was prohibited and defined maltreatment as abuse, neglect, and exploitation/theft. The policy indicated all staff were trained to identify maltreatment and were mandated reporters of maltreatment. Staff were trained at the time of hire and annually thereafter. Section 5. indicated staff who suspect maltreatment of a resident or has knowledge that a resident sustained a physical injury that could

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0 620	Continued From page 14 not be explained will. Section A. take immediate action to protect and keep the resident affected safe. Section B. call 911 if emergency assistance is needed. Section C. contact the clinical nurse supervisor if medical attention is needed. Section D. contact the LALD. Section E. the LALD and clinical nurse supervisor would determine how to protect other residents from similar maltreatment. Section F. indicated if the LALD or clinical nurse supervisor confirmed the suspicion of maltreatment, a report was made to the MAARC no later than 24 hours after the maltreatment was first suspected. The policy indicated ALL staff had the right to report suspected maltreatment to MAARC or law enforcement. Section K. indicated staff would not be retaliated against for making a good faith report of suspected maltreatment. The policy failed to instruct staff to internally report suspected maltreatment immediately, and indicated the facility failed to follow their policy to report suspected maltreatment to MAARC no later than 24 hours after being made aware of an incident of potential maltreatment. No additional information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 interview and document review, the facility failed to ensure 1 of 1 residents reviewed,	02360		

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02360	Continued From page 15 (R1) was free from maltreatment. R1 was neglected and abused. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, the facility and an individual were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		