Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334497488M
Compliance #: HL334494123C

Date Concluded: September 1, 2023

Name, Address, and County of Licensee Investigated:
Willows of Arbor Lakes
11955 80th Avenue North
Maple Grove, MN 55369
Hennepin County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Inconclusive

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 perpetrators (AP1 and AP2) abused a resident when they grabbed the resident's arms during cares, causing bruising.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The resident reported AP1 and AP2 grabbed and twisted her wrists. AP1 and AP2 stated the resident was combative during cares but they did not grab or twist the residents' arms/ wrists. The resident had discoloration, possible bruising, on her right forearm later that day. It could not be determined how or when the resident received the bruises.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted the resident's care manager. The investigation included review of medical records, facility policies and procedures, the facility internal investigation, photographs, staff training, and employee files.

The resident resided in an assisted living memory care unit with diagnoses including vascular dementia. The resident's service plan included assistance with medications, bathing, dressing, grooming, meals, and safety checks. The resident's assessment indicated the resident often refused assistance with cares.

A facility investigation indicated the resident reported AP1 and AP2 grabbed her wrist and twisted it during cares. The report indicated AP1 and AP2 assisted the resident with toileting after the resident was incontinent. AP1 and AP2 stated the resident was combative during cares and was trying to hit them. AP1 and AP2 stated they held the resident's hand to prevent her from hitting them. Both staff members denied twisting the resident's wrist and/ or twisting them.

During an interview, the facility nurse stated the resident often refused staff assistance with cares. The nurse stated the resident's care manager reported to her the resident had an odor and the nurse asked one of the caregivers to assist the resident with toileting. Later in the day, AP1 came to the nurse's office and reported she was able to clean the resident, but the resident was combative during toileting because she did not want assistance. AP1 told the nurse the resident had been grabbing her and AP2's clothes and hair and was trying to hit them. The nurse stated when she was speaking with AP1, the resident came into the office and told the nurse, "The girls roughed me up." The nurse asked the resident what happened, and the resident said, "them girls made me get dressed." The nurse stated she spoke to the resident's care manager and the care manager reported the resident told her staff squeezed and twisted the resident's arm. The nurse stated she immediately went to look at the residents' arms and she did not see any bruising on the resident's arms. The nurse stated the resident's arms appeared to have frail, dry skin. The nurse stated she took pictures of the resident's arms.

Photos of the resident's right arm indicated two areas of red discoloration, one on the middle forearm and one higher up on the inner right forearm. No bruising was observed on the residents left arm.

During an interview, AP1 stated herself and AP2 were assisting the resident after an incontinent episode. AP1 stated the resident allowed them to assist her to the bathroom, but once they got into the bathroom the resident started swearing, hitting out, and pulling on their clothes. The resident grabbed on to AP2's shirt. AP1 denied she or AP2 grabbed the resident's hands or arms.

In an interview, AP2 stated AP1 asked for assistance to toilet the resident. AP2 stated the resident went willingly with them to the bathroom, but once they got to the bathroom the resident grabbed AP2's shirt in her hands and held onto her tight. The resident was standing with her pants down while AP1 wiped her backside. The resident continued to grab AP2's shirt in several places. AP2 stated she was attempting to talk with and console the resident while she was being cleaned. AP2 denied grabbing the resident's hands, arms, or wrists.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided education with staff on vulnerable adults and dementia care.

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
	33449	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF ARBOR LAKES	11955 80TH AVENUE NORTH MAPLE GROVE, MN 55369

(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 August 8, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL334494123C/#HL334497488M. No correction orders are issued.	0 000		