Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307646684M
Compliance #: HL307642568C

Date Concluded: November 15, 2023

Name, Address, and County of Licensee Investigated:
The Lodges on Natchez
27890 Natchez Avenue
Elko New Market, MN 55020
Scott

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Inconclusive**

Nature of the 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) verbally abused a resident when she called the resident "fat".

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While the AP may have treated the residents in a discourteous manner, there was insufficient evidence to demonstrate abuse occurred. Attempts to interview employees who may have witnessed the interactions between the AP and the resident were not successful.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the AP's personnel record, facility's policies and procedures, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses include schizoaffective and borderline personality disorder. The resident's service plan included redirection regarding medication times and administration. It also indicated the resident was independent with activities of daily living.

The resident's progress notes indicated the resident reported during a care conference that the AP called her fat when she asked for a sandwich at 2 am one night. The resident also said the AP had at times refused to help her clean her room, clip her toenails, and assist with putting on her shoes. The same document indicated the AP told other employees the resident "can do it herself" when those employees tried to provide on these tasks.

During an interview, the AP said she had worked for the facility for four years and was let go due to this situation. She stated the resident was self-sufficient and expressed a desire for staff members to hold her accountable for weight loss. The AP stated she never called the resident fat or used offensive language. She recounted on the night in question, she made a sandwich for the resident, who then requested another one, so the AP reminded the resident about her earlier request regarding weight loss. She stated she did assist the resident with tasks like tying her shoes, but she also believed the resident was capable of doing it independently and encouraged her to do so. The AP stated she declined to cut the resident's toenails because they were thick and suggested the resident needed to see the doctor or nurse for that.

During an interview, a member of the management team stated she received a report from the resident, alleging the AP made comments about her weight, including calling her fat and refusing to help with her shoes. The member of management acknowledged the resident's upset feelings about these comments. Additionally, she heard from other staff members who confirmed the AP had been disrespectful to the resident. One staff member reported the AP refused to clean the resident's room, advising her to do it herself to lose weight. While the management staff did not personally witness these events, she gathered information from staff members and decided to terminate the AP after the investigation.

During the investigation, despite making multiple attempts, the investigator was unable to reach the other unlicensed caregivers who the management team member stated reported inappropriate statements on the part of the AP.

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: No, attempts to interview the resident were not successful
Family/Responsible Party interviewed: No, the resident is her own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility initiated an investigation and terminated the AP. Re-education was provided to other staff members who witnessed the incidents but did not report them promptly. Additionally, a camera was installed after the incident in one of the common areas of the facility.

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
	30764	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON NATCHEZ	27890 NATCHEZ AVE ELKO, MN 55020

(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 October 4, 2023, the Minnesota Department of Health initiated an investigation of complaint HL307646684M/HL307642568C. No correction orders are issued.	0 000		