Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308015284M **Date Concluded:** October 24, 2024
Compliance #: HL308017321C

Name, Address, and County of Licensee Investigated:
Willows & Waters Senior Living
707 Upper Meadow Lane NW
Rochester, MN 55901
Olmsted County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Michele Larson, RN
Special Investigator

Finding: Substantiated, 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):
Alleged perpetrators (AP#1, AP#2), facility staff members, emotionally abused resident #1 and resident #2. AP#1 and AP#2 demeaned and humiliated resident #1 and resident #2 when AP#1 wrapped a long, metal chain link chain around resident #1 and resident #2's forearm and wrists without their consent. AP#2 recorded the incidents from her personal cell phone then posted the disrespecting videos on social media (Facebook), a violation of resident #1 and resident #2's privacy rights.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. AP#1 and AP#2 and were responsible for the maltreatment. AP#1 admitted she put the chain around resident #1 and resident #2's wrist and forearms but stated it was meant as a joke. AP#2 denied posting the video footage on social media (Facebook) even though evidence confirmed the resident's videos were posted from AP#2's social media (Facebook) account.

The investigator conducted interviews with administrative staff and nursing staff. The investigation included review of resident #1 and resident #2's records, resident #2's death record, AP#1, and AP#2's employee files, staff schedules, the law enforcement report, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during the onsite investigation.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included dementia. Resident #1's service plan included assistance with activities of daily living. Resident #1 was forgetful with short-term memory loss, and not oriented to person, place, or time. Resident #1 used a four-wheeled walker and required a gait belt and staff assist of one for transfers.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included paranoid schizophrenia and bipolar disorder. Resident #2's service plan indicated resident #2 required assistance with activities of daily living. Resident #2 was unable to walk, used a mobility (Broda) chair, and required a sit-to-stand lift and gait belt for transfers. Resident #2 was cognitively impaired, unable to report abuse, and was susceptible to being abused by another individual.

Evidence collected during the investigation identified AP#1 in resident #1 and resident #2's video footage that was posted on social media. In addition, evidence collected identified resident #1 and resident #2's videos were posted from AP#2's social media account.

In an undated cell phone video footage with no sound, resident #1 was shown seated in a recliner with his legs elevated. AP#1 stood next to the recliner on resident #1's right side. AP#1 held and dangled an approximate four-foot-long metal chain with approximately one-and-a-half-inch chain links in her hands. Resident #1 looked up and smiled at AP#1 as she leaned down to speak to resident #1 then quickly wrapped the metal chain around his right forearm near his wrist. Resident #1 stopped smiling as he looked down at the chain around his wrist attempting to take it off.

Review of another undated cell phone video footage with no sound, showed resident #2 seated at the head of a long dining table eating food from both her hands. AP#1 quickly appeared in the video holding the same long metal chain link chain. From resident #2's left side AP#1 wrapped the metal chain around resident #2's left wrist then using the chain, pulled resident #2's left arm above her head. AP#1 was looking directly into AP#2's cell phone camera, smiling. Resident #2 appeared unhappy and continued to attempt to eat food from her right hand. AP#1 lowered resident #2's arm to the table but kept the chain wrapped around resident #2's left wrist. AP#1 leaned close and spoke to resident #2. It was unclear what AP#1 said to resident #2 but resident #2 appeared upset as she mouthed the word "NO" to AP#1.

Review of AP#1's personnel file indicated the facility provided AP#1 with training regarding vulnerable adults and resident rights.

Review of AP#2's employee file indicated leadership requested AP#2 immediately delete the videos of resident #1 and resident #2. AP#2 agreed she would delete the videos "right away." The facility provided AP#2 with training regarding vulnerable adults and resident rights.

When interviewed, AP#1 admitted she wrapped the chain around resident #1 and resident #2's arm and wrists. AP#1 stated she thought she found the chain inside a drawer in the facility. AP#1 stated she was "just having some fun," stating resident #1 laughed during the incident. AP#1 denied she knew AP#2 was recording her and stated AP#2 had a vendetta against her for incidents that happened years ago. AP#1 acknowledged the incidents "looked bad," and did not recall if she received vulnerable adult training but stated "at some point I probably was."

When interviewed, AP#2 initially stated AP#1 was unaware she was being recorded by AP#2, stating she zoomed in when AP#1 wrapped the metal chain around resident #1 and resident #2. However, three days later, AP#2 stated to the investigator that AP #1 was aware of AP#2 recording AP#1 using a chain on resident #1 and resident #2. AP#2 stated, "I told AP#1 I was recording her, and she said I don't care." AP#2 stated she recorded AP#1 chaining resident #1 and resident #2 because leadership told her to do so if AP#2 witnessed any abuse happening to any resident, otherwise leadership would not believe AP #2. AP#2 stated she had no idea why AP#1 would do that to the residents. AP#2 denied posting the videos on social media but stated AP#2's family member "tried" to post the videos but was unsuccessful. AP#2 stated she shared the videos with other people in the community because she wanted people to know AP#1 abused resident #1 and resident #2. AP#2 stated she was unaware posting the resident's videos on social media violated resident #1 and resident #2's rights.

When interviewed, leadership stated they immediately disciplined AP#1 and AP#2 after viewing resident #1 and resident #2's videos. Leadership stated AP#1 received a call from a former staff member stating AP#1 was seen in videos posted on social media tying up resident #1 and resident #2 in chains. Leadership stated although they and AP#1 were unable to find the video on social media it still disturbed them to know the videos were posted. Leadership stated, "there was no harm to the residents," stating resident #1 and resident #2 smiled and laughed in the videos, stating there was sound at the time leadership viewed the videos. Leadership stated, "Nobody was tied down or restrained."

When interviewed, resident #2's legal guardian stated the facility did not notify her regarding resident #2's video footage and incident. The legal guardian stated the incident was "very serious," stating "you don't joke with that. This is not joking."

In conclusion, the Minnesota Department of Health determined 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: Yes. Resident #1 was interviewed. Resident #2 died shortly after the incident.
Family/Responsible Party interviewed: Yes. Resident #2's legal guardian was interviewed.
Alleged Perpetrator interviewed: Yes. Both AP#1 and AP#2 were interviewed.

Action taken by facility:
The facility gave a written warning to AP#1 and AP#2 regarding the incidents. Facility leadership provided education on the vulnerable adult act and resident privacy to both AP#1 and AP#2.

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 parties 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
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL308017321C/#HL308015284M On September 26, 2024, 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 12 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL308017321C/#HL308015284M, tag identification, 2350 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 Facilities. 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 evaluators' 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.	
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02350	Continued From page 1 courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two residents (R1, R2) were treated with dignity and respect. In unauthorized recorded videos, unlicensed personnel (ULP)-A demeaned and humiliated R1 and R2 when she wrapped a metal chain around R1 and R2's arms and wrists. ULP-B recorded the videos from her personal cell phone and posted R1 and R2's humiliating videos on social media, a violation of the Health Insurance Portability and Accountability Act (HIPAA) and R1 and R2's privacy rights. This practice resulted in a level three violation (a violation that harmed a resident'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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 was admitted to the licensee's facility on September 18, 2023. R1's diagnoses included dementia and diabetes. R1's assessment dated October 2, 2023, indicated R1 required assistance with all activities of daily living (ADL)s and transfers. R1 was forgetful with short-term memory loss. R1 used a four-wheeled walker for ambulation and a gait	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02350	Continued From page 2 belt for transfers. R1's Individual Abuse Prevention Plan (IAPP) dated June 17, 2024, indicated R1 was not oriented to person, place, or time due to dementia. R2's medical record was reviewed. R2 was admitted to the licensee's facility on June 14, 2022, and resided there until her death on April 4, 2024. R2's diagnoses included paranoid schizophrenia, bipolar disorder, and abnormal gait. R2's service plan dated October 20, 2022, indicated R2 received assistance with personal cares, medication management, toileting, transfers, safety checks, meals, housekeeping, and laundry. R2 was unable to walk and used a Broda (highback) wheel chair, a gait belt, and standing lift for transfers. R2's IAPP dated October 2, 2023, indicated R2 was unable to report abuse and was susceptible to being abused by another individual. R2's assessment dated December 18, 2023, indicated R2 was cognitively impaired. In an undated cell phone video footage with no sound, R1 was shown seated in a recliner in the common area with his legs elevated. ULP-A stood next to the recliner on R1's right side holding and dangled a long, metal chain with approximately one-and one-half inch links, in her hands. ULP-A leaned down and appeared to say something to R1 who looked up and smiled at ULP-A then mouthed "huh?" to ULP-A. ULP-A then wrapped the metal chain around R1's right forearm near his wrist. R1 stopped smiling and looked	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02350	Continued From page 3 concerned as he tried to take the metal chain off his right arm. Review of another undated video footage with no sound, showed R2 seated at the head of a long dining table eating food from both hands. ULP-A quickly appeared on the video walking up to R2's left side holding the same metal chain she had in R1's video. ULP-A laughed directly into ULP-B's cell phone's camera as she wrapped R2's left wrist with the metal chain then raised R2's left arm above R2's head. R2 appeared unhappy but still attempted to eat during the incident. ULP-A lowered R2's left arm but kept the metal chain wrapped around R2's wrist. ULP-A leaned in close to R2 to say something to her. It was unclear what ULP-A said to R2, but R2 appeared upset and mouthed the word "NO" to ULP-A. Review of ULP-A's employee file indicated ULP-A's hire date was January 11, 2024. ULP-A's signed job description dated January 11, 2024, indicated she understood and adhered to the vulnerable adult abuse policy, resident bill of rights, and HIPPA rights. On January 11, 2024, ULP-A received training on Minnesota Vulnerable Adult's Act; compliance with and reporting suspected maltreatment of vulnerable adults. Review of ULP-B's employee file indicated ULP-B's hire date was October 13, 2022. ULP-B's signed job description dated October 13, 2022, indicated she understood and adhered to the vulnerable adult abuse policy, resident bill of rights, and HIPAA rights. On March 5, 2024, ULP-B received annual training on Minnesota Vulnerable Adult's Act; compliance with and reporting suspected maltreatment of vulnerable adults. ULP-B was terminated on June 26, 2024, months after receiving employee counseling for	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02350	Continued From page 4 posting the videos on social media. Reasons for ULP-B's termination included: recording videos on personal phone, resident rights, insubordination, and HIPPA violation. A document titled "Employee Counseling-Step 1," dated April 15, 2024, and completed by owner (OW)-C, indicated ULP-A was disciplined for being recorded by another staff (ULP-B) for "joking around about tying up a resident." OW-C indicated recording and photographing residents was against facility policy, unacceptable, and would not be tolerated. OW-C indicated ULP-A would be immediately terminated if the behavior occurred again. Another document titled, "Employee Counseling-Step 1," dated April 15, 2024, and completed by OW-C, indicated OW-C received videos from ULP-B that ULP-B recorded from her cell phone. The videos showed ULP-A "messing and joking around with two residents." (R1, R2). OW-C reiterated it was not acceptable to talk about tying up a resident. OW-C requested ULP-B immediately delete the recorded videos from her phone. ULP-B indicated she would delete the videos "right away," and would never joke around with residents and ULP-A. OW-C indicated ULP-B would be terminated if it occurred again. In a legal letter dated August 14, 2024, written by OW-C's attorneys to ULP-B, indicated ULP-B immediately cease and desist sharing and posting R1 and R2's videos in addition to requesting ULP-B immediately remove unauthorized data from her electronic devices. During an interview on September 26, 2024, at 12:40 p.m., ULP-A admitted she put the metal	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02350	Continued From page 5 chain around R1 and R2 but stated she was "just having some fun," stating R1 laughed. ULP-A stated she may have found the chain inside a drawer in the facility. ULP-A denied she knew ULP-B was recording the incidents from her cell phone. ULP-A thought the incidents occurred in February 2024 but was unsure. ULP-A acknowledged the incidents "looked bad." ULP-A stated ULP-B posted the videos on social media after ULP-B was terminated. ULP-A stated, "ULP-B has a vendetta against me for stuff that happened eight years ago." ULP-A stated she did not recall if she received vulnerable adult training but stated "at some point I probably was." During an interview on September 27, 2024, at 9:40 a.m., ULP-B initially stated ULP-A was unaware ULP-B recorded her chaining R1 and R2, stating she zoomed in with her cell phone to record ULP-A's acts. ULP-B stated she had no idea why ULP-A would do that to R1 and R2. ULP-B stated she showed the videos to OW-C "right away" but stated OW-C did not do anything after she viewed the videos. ULP-B denied she posted R1 and R2's videos on social media and stated her sister "tried" to post the videos but stated the videos were rejected. ULP-B stated she thought she recorded the videos in March 2024 and stated she shared the videos with several people who were unassociated with the facility because she wanted them to see R1 and R2 were being abused by ULP-A. ULP-B stated she was unaware posting R1 and R2's videos violated their HIPPA rights. On September 27, 2024, at 4:12 p.m., ULP-B left a recorded voice message on the investigator's work phone. ULP-B indicated she recorded the videos because she was told by OW-C to record any suspected abuse so there would be proof,	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02350	Continued From page 6 otherwise OW-C would not believe it stating, "It was the right thing to do." On September 30, 2024, at 8:09 a.m., ULP-B called the investigator and recanted what she initially said during her first interview with the investigator. ULP-B stated ULP-A knew ULP-B was recording ULP-A wrapping the chain around R1 and R2. ULP-B stated, "I told ULP-A I'm recording her, and ULP-A said I don't care." During an interview on October 1, 2024, at 1:00 p.m., OW-C stated on April 15, 2024, she immediately disciplined ULP-A and ULP-B upon viewing the videos. OW-C stated a former staff member called ULP-A telling ULP-A the videos were posted on social media but stated both she and ULP-A were unable to find R1 and R2's videos on social media. OW-C stated she did not file a Minnesota Adult Abuse Reporting Center (MAARC) report because "there was no harm to the residents," stating R1 and R2 were laughing in the videos and there was sound at the time she viewed the videos. OW-C stated, "Nobody was tied down or restrained." During an interview on October 3, 2024, at 3:49 p.m., R2's legal guardian (LG)-E stated she was completely unaware of R2's incident stating OW-C never informed her about R2's incident. LG-E stated it was "very serious" stating,"You don't joke with that. That is not joking." The licensee policy titled Video and Photography, dated August 1, 2021, indicated all photographs and/or video taping of residents were not permitted without resident's expressed consent. TIME PERIOD TO CORRECT: Seven (7) days.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(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
02360	Continued From page 7	02360		
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: The facility failed to ensure two of two resident(s) reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction required.	