Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5295253M
Compliance #: H5295245C

Date Concluded: May 31, 2022

Name, Address, and County of Licensee Investigated:
The Emeralds of St. Paul
420 Marshall Avenue
St. Paul, MN 55102
Ramsey County

Facility Type: Nursing Home

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Inconclusive

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.

Allegation(s): The Alleged Perpetrator (AP) abused a resident when the AP slapped the resident on the arm.

Investigative Findings and Conclusion:
Abuse is inconclusive. The witness stated the AP "smacked at" the resident's hands twice, it all happened quickly, and she could not remember specifics as it had been a while since the incident and all the days blended together. The AP stated she quickly pulled away from the resident who had grabbed her hand twice but denied having slapped the resident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed personnel records, facility policies, and procedures related to maltreatment of vulnerable adults, and employee code of ethics.

The residents medical record indicated the resident was admitted to the facility after a fall. The resident had lived independently, but due to multiple falls, required emergency guardianship. The resident's diagnoses included diabetes, personality disorder, chronic obstructive pulmonary disease, and obesity. The resident received services from the facility that included assistance of two staff for toileting, peri-cares, incontinence cares, assistance of two staff with movement in bed, and assistance of two staff with transfers using a full mechanical lift.

A facility report indicated two staff (unlicensed personnel and the AP) entered the resident's room to help her to bed one evening. The report indicated they adjusted the sling to prepare to attach it to the mechanical lift, when the resident slapped the AP's arm, who then slapped the resident's arm. The report indicated an investigation began with interviews of staff and residents. No staff or residents expressed safety concerns or similar experiences with the AP.

During an interview, the unlicensed personnel stated she and the AP entered the resident's room to assist the resident into bed. The unlicensed personnel stated the resident was in her wheelchair. The unlicensed personnel stated she and the AP were on opposite sides of the resident's wheelchair, and she did not hear a slapping sound, but saw the resident "smack at" the AP, who then "smacked at" the resident. The unlicensed personnel stated this occurred twice and the resident began to scream, so she and the AP left the room until the resident calmed down. The unlicensed personnel stated they re-approached the resident ten minutes later and got the resident settled into bed without a problem. The unlicensed personnel stated she informed the nurse on duty, who called the administrator.

During an interview, the administrator stated the unlicensed staff had called him after the incident. The administrator stated he briefly interviewed the AP and sent her home while he started an investigation. The administrator stated a nurse assessed the resident and found no injuries. The administrator stated no residents or staff reported other incidents with the AP.

During interviews, several other unlicensed personnel stated the resident had a history of slapping and yelling at staff. The unlicensed personnel stated they received training to ensure the resident's safety, leave the resident's room, and re-approach the resident when she calmed. Two of the unlicensed personnel stated the resident was more aggressive with staff of color.

During an interview, the AP stated the resident would often slap the staff or grab at their arms. The AP stated on the night of the incident, the resident grabbed the AP's arm and the AP quickly pulled it off. The AP stated the resident did the arm grabbing again, the AP quickly pulled away, but the resident began screaming so they left the room. The AP stated when they went back ten minutes later the resident cooperated and they got her into bed for the night.

In conclusion, it was inconclusive whether abuse occurred.

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.
(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, at the request of the guardian.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Mental Health and Developmental Disabilities
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: _____ B. WING _____	C 05/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5295253M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/02/22

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		

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