*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL204471160M
**Compliance #:** HL204471420C

**Date Concluded:** May 20, 2025

**Name, Address, and County of Licensee Investigated:**
Walker Methodist Place
3701 Bryant Ave South
Minneapolis, MN 55409
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Brandon Martfeld, RN, BSN, 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 (AP #1 and AP #2), facility staff members, abused the resident when they hit the resident while providing the resident medications and cares.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was inconclusive. During the investigation it was determined AP #1 was involved in the incident with the resident. AP #1 denied hitting the resident and the resident was not able to identify the staff or the events of the altercation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a witness to the incident. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report,

and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety and dementia. The resident's service plan included assistance with behavior interventions for anxiety and agitation, medication administration, toileting, and dressing. The resident's assessment indicated the resident used a wheelchair and a walker for mobility and was at risk for abuse.

A progress note indicated one day AP #1 called the on-call nurse to report the resident hit her multiple times while trying to administer medications and while trying to assist the resident with taking her shoes off. After providing cares, the resident came out of her apartment into the hallway and was yelling "someone help me, she hit me."

The facility investigation indicated the resident reported that an unidentified staff member hit her. The resident was found with a bruise to her left cheek. The resident denied being hit in the face and was not able identify who hit her. AP #1 was identified as the staff person assigned to care for the resident that shift. The facility investigation noted older bruises to the resident's left forearm and a light bruise to the resident's right forearm.

During an interview, a staff member stated they were distributing reading material for the residents one night. When he arrived at the second floor, a resident was in the hallway saying, "she hit me, she hit me." The resident was distraught. The staff member stated they did not see any marks or redness on the resident. Leadership was notified.

During an interview, leadership stated she received a phone call from a staff member that the resident was in the hallway saying, "she hit me, she hit me." Leadership stated she spoke with the resident. The resident was observed with a bruise on her face but denied being hit in the face. The resident reported she was hit, but then indicated she was grabbed by each shoulder and shook. The resident then stated she was hit on her shoulders. A skin check was completed and there was no indication the resident was hit on her chest or shoulders. Leadership stated other residents were interviewed with no care concerns. Leadership stated AP #1 was removed from floor and suspended pending a facility investigation, and local law enforcement was called.

During an interview, a nurse stated the resident was known to become angry with staff and hit staff. The nurse stated the resident said, "she hit me", but the resident could not identify the staff person. The resident could not verbalize where she was hit, but indicated she was hit in her arm. The resident denied being hit in the face.

During an interview, AP #1 stated the night of the incident she was working with the resident. AP #1 brought the resident's medications to her and asked the resident if she wanted the medications or to get ready for bed. The resident wanted her medications first and when the medications were handed to the resident, the resident hit AP #1 on the hand. AP #1 told the

resident, please do not hit me, if you do not want to take you medications just tell me. The resident agreed to take her medications and when the resident was given her medication, the resident hit AP #1 with a water bottle. After receiving the medications, AP #1 assisted the resident into the bathroom to get ready for bed. AP #1 stated in the bathroom the resident attempted to hit her again. AP #1 told the resident to please stop, why do you keep hitting me. When AP #1 removed the resident's shoes the resident hit AP #1 with the shoe. AP #1 put her arm out to “dodge” the resident’s attempted strike with the shoe. The resident then started to scream and yell, saying “you hit me.” AP #1 assisted the resident out of the bathroom, into a chair, and left the resident’s apartment. AP #1 stated a few minutes after completing cares with another resident, the resident was in the hallway screaming. AP #1 contacted the on-call nurse, and leadership came to the facility. AP #1 denied hitting the resident.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

**Vulnerable Adult interviewed**: No. The vulnerable adult declined.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
The facility suspended the AP and completed an internal investigation. The AP is no longer employed at 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 |
|---|---|---|---|
| | 20447 | A. BUILDING: _____ B. WING _____ | C 05/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST PLACE | 3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 |

| (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<br><br>On May 5, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL204471160M/#HL204471420C. No correction orders are issued. | 0 000 | | |