DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL21141001M
Compliance #: HL21121002C

Date Concluded: July 27, 2022

Name, Address, and County of Licensee Investigated:
Emerald Crest
451 East Travelers Trail
Burnsville, MN 55337
Dakota County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused the resident when she forcibly removed the resident from a peer's apartment, and then forcibly remove a cell phone from the resident's hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP forcibly grabbed the resident and pushed her out of another resident's apartment and into the hallway. The AP later initiated a struggle when she forcibly grabbed the resident to remove a cell phone from the resident's grasp. After the altercations, the resident developed a bruise on her left upper arm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator consulted with law enforcement. The investigation included review of the resident's medical record, staff training records, facility

policies and procedures, video footage of the incidents, and the police report. In addition, observations were completed of staff and resident interactions during cares and activities.

The resident resided in an assisted living memory care unit and had diagnoses including dementia. The resident received assistance with dressing, grooming, meals, medication management, laundry, and housekeeping. The resident's assessment indicated the resident had cognitive abulia (a loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action).

When interviewed, an administrator stated staff were made aware of the incident when the AP called a registered nurse to inform her that the AP was going to urgent care. The AP stated the resident came at her and scratched her. The administrator stated the AP said another staff member had called her over to the resident's unit to assist with transferring another resident. The resident was in the other resident's apartment, and the AP tried to get the resident out. In the second incident, the AP overheard the resident saying she was looking for a phone to call 911. The AP stated as she tried to get the phone from the resident the resident "came after her." The administrator stated once staff reviewed the video footage, they felt the AP's description of the incident was not accurate. The police were notified, and the AP's employment was terminated.

When interviewed, unlicensed personnel (ULP) stated he called the AP over from another unit (house) to help him with a transfer. The ULP stated the resident was a former caregiver and would sometimes imitate staff and try to help other residents. The resident had entered her peer's apartment and attempted to help with the transfer. When the resident did not leave, the ULP stated the AP pulled the resident out of the apartment. The ULP continued to help the resident's peer when the AP walked out of the apartment. The ULP soon after heard the resident yell, so he left the other resident's apartment. As he neared the kitchen, the ULP saw the AP blocking the resident with one hand and pushing the resident with her other hand.

During an interview, a registered nurse (RN) stated she received a call from the AP. The RN state the AP was in "hysterics" and said the resident tried to attack her and bite her. The RN stated this would have been unusual behavior for the resident, and upon reviewing video footage of the incidents, the RN contacted an administrator to initiate further investigation. The RN completed a skin check of the resident and saw nothing out of the ordinary. The RN continued skin checks daily, and on the second day after the incidents, the RN noted a bruise had formed on the resident's left upper arm, measuring 3.5cm x 4.2cm.

When interviewed, the AP stated the resident was already agitated when she arrived at the house to help with another resident, and it was the other ULP who pushed the resident out of her peer's apartment. In the kitchen, the AP stated the resident initiated the altercation, while another resident tried to hit her with a phone. The AP stated she was protecting herself and denied the allegation.

Review of the video footage revealed the AP pushed the resident out of a peer's apartment. The AP had one hand around the resident's upper right arm and was holding the resident's arm above her shoulder. The AP pushed the resident out of the door, with both hands around the resident's right arm. The AP's left hand was holding the resident's right upper arm and the AP had her right hand on the resident's right lower arm. Once the AP and resident were both outside the door, the AP pushed the resident away from the door and released the resident's arm as she did so. The resident lost her balance and tripped slightly backward. The AP walked back into the room. The resident started walking in the direction toward the camera and was rubbing her upper left arm.

After a few minutes, the video showed the resident and a peer standing in the kitchen. The AP entered the scene from the left and walked toward the kitchen. The resident walked toward the entrance of the kitchen as the AP entered. The AP then grabbed the resident by her right arm. The AP yanked the resident's arm repeatedly as the resident struggled against the AP. With the AP's back to the camera, a struggle continued between the AP and the resident. The resident's peer walked toward the resident and the AP as they were struggling and reached out an arm toward the resident. After pushing the resident away, the AP unhanded her. A second staff member (ULP) entered the scene, walked to the kitchen, and appeared to converse with the resident and her peer. The AP left the kitchen, grabbed a coat, and exited the building.

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: No, due to cognitive deficit.
Family/Responsible Party interviewed: No, family was informed of investigation.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility filed a MAARC report, initiated an internal investigation, and provided retraining to staff regarding vulnerable adult statutes and policies. The AP is no longer employed with the facility.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

The responsible party 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
Dakota County Attorney
Dakota City Attorney
Burnsville Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21141	A. BUILDING: ______ B. WING ______	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF BURNSVILLE	**457 EAST TRAVELERS TRAIL BURNSVILLE, MN 55337**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL21141002C/#HL21141001M On June 28, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order was issued. At the time of the complaint investigation, there were 50 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL21141002C/#HL21141001M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

Minnesota Department of Health

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02360	Continued From page 1 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: Based on observations, interviews, and document review, the facility failed to ensure one of one resident, R1, was free from maltreatment. R1 was abused. Findings include: On June 28, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	