Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211415683M
Compliance #: HL211419857C

Date Concluded: January 3, 2024

Name, Address, and County of Licensee Investigated:
Emerald Crest of Burnsville
457 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 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), facility staff, abused a resident when the AP hit the resident on the head and back several times with an open and closed hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was witnessed [by a facility staff] repeatedly hitting the resident with an open and closed hand on the back of the head. The AP told the witness the resident was not listening to the AP. The staff comforted the resident and reported the incident to facility leadership.

The investigator conducted interviews with facility staff including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family. The investigation included review of the resident's medical chart, the AP employment file, facility

policies and procedures, the internal investigation, and court documents. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included unspecified dementia, agitation, depression, and insomnia. The resident's service plan included assistance with activities of daily living, meals, and medication management. The resident's assessment indicated the resident was at risk for abuse by others.

The facility investigation indicated a staff walked by the resident's room and witnessed the AP standing next to the resident hitting the resident with an open and closed fist in the head and back. The staff confronted the AP, and the AP stated the resident was not listening to him. The AP then left the resident's room. The staff member comforted the resident and asked her if she was okay. The resident replied, "No, did you see how hard he was hitting me? He almost took my head off." The staff member reported the incident to leadership. The AP was immediately removed from the facility and suspended pending the full investigation, and staff called the police. No visible injuries were found on the resident during a nurse assessment and the resident did not recall the incident when interviewed. The AP denied the allegation when interviewed. Camera footage of the hallway corroborated the times the staff and AP said they entered and exited the resident's room. There was no camera footage from inside the resident's room.

Court records indicated the AP plead guilty to and was convicted of Assault-5th Degree-Misdemeanor resulting from the incident with the resident.

When interviewed a nurse stated she received a report a staff witnessed the AP hitting the resident with an open and closed fist across the head. When the nurse interviewed the AP, he denied hitting the resident. The nurse reviewed video footage of the hallway outside the resident's room and verified the staff member and AP entered and exited the resident's room at the times they said they did. There was no camera footage inside the resident's room. The nurse assessed the resident for injury, and the resident did not remember the incident.

When interviewed, a staff stated she walked by the resident's room, and the door was open. When she looked into the room, she saw the AP hitting the resident on her back and head. The blows were quick and fast, and the resident was trying to duck and move, but the AP would follow the resident with the hits. The staff stated the AP hit the resident with a fist and open hand, on her head and back. The staff entered the resident's room and confronted the AP. The AP stated the resident was not listening to what he was saying. The staff asked the resident if she was okay, and the AP walked out of the room. The resident told the staff, "[AP] almost took my head off, didn't he?" The staff reported the incident to facility leadership.

When interviewed, the AP denied the allegation.

When interviewed, a family member stated she visited the resident immediately after the facility notified family of the incident. The resident did not recall the incident, however, the resident complained of pain in her back and head.

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. Unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The facility provided vulnerable adult retraining to staff.

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.

You may also call 651-201-4200 to receive a copy via mail or email

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
Burnsville City Attorney
Burnsville Police Department

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 12/04/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL211419857C/ #HL211415683M and #HL211412817C/ #HL211416805M On December 4, 2023, 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 63 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL211419857C/#HL211415683M and #HL211412817C/#HL211416805M, tag identification 2360.	0 000	No plan of correction is required for this tag.	
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	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		