Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211416805M
Compliance #: HL211412817C

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 the resident when the AP grabbed the resident's arm, slapped and pushed the resident, and physically restrained the resident until the resident fell to the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP forcibly grabbed a fork out of the resident's hand and antagonized the resident until the resident began to swat at her. The AP then slapped the resident's hands, pushed the resident away, and then restrained the resident by grabbing the resident's wrist and placing the resident in a bear hug from which the resident struggled to free herself. As the resident struggled to get out of the AP's restraint, the resident fell to the floor. The resident developed a bruise to her right upper arm.

The investigator conducted interviews with facility staff including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's family. The investigation included review of the resident's medical record, the AP file, facility policy and procedures, and the internal investigation. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included early onset Alzheimer's disease with behavioral disturbance. 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's internal investigation indicated one weekend the AP called the on-call triage service to report the resident attacked her. The AP stated the resident scratched and hit her, but the resident eventually calmed down. A facility nurse received the report two days later upon returning to work from the weekend. The nurse reviewed recorded video footage and the AP was seen pushing and restraining the resident, resulting in the resident falling onto the floor. The nurse assessed the resident and indicated the resident had a 6 x 3.5-centimeter (cm) bruise on the right upper arm. The nurse indicated after review of the recorded camera footage it appeared the resident's behavior was triggered by the AP. The investigation indicated the AP approached the resident in an inappropriate manner, which led to the resident falling.

The internal investigation included an interview with the AP conducted by a police officer. The AP stated the resident "kicked my butt." and scratched and bit her. When asked what triggered the incident, the AP stated she attempted to remove a fork from the resident's hand because the resident was walking around and attempting to stab other residents. The resident became upset and started to hit the AP. The AP walked away, and the resident returned and started to poke the AP. The AP stated she attempted to redirect the resident when the resident began to scratch and bite her. The AP stated she never touched the resident but kept her hand in front of her to protect herself from the resident. Although the AP viewed the recorded video of the incident, the AP continued to repeat she never touched the resident, and the resident injured her.

Review of a medical document indicated the resident experienced agitation at times but responded well to redirection and reapproach. Prescriber orders instructed the facility to continue psychotropic medications, monitor for paranoia, and continue to use the reapproach technique for incidents of agitation.

The recorded video of the incident indicated the resident was observed in the dining room sitting at a table. The resident got up to bring dishes to the kitchen counter. As the resident stood at the counter, the AP entered the dining room from the left. The resident walked back to her table with a utensil in her left hand. The resident began to pull her chair away from the table when the AP walked up behind her, forcibly grabbed the utensil from the resident's hand, and then reached across the resident to remove a cup from the table. The resident became

agitated and swatted at the AP's right arm. The resident again reached for the AP's right arm, and the AP slapped the resident's left hand away. The resident swatted at the AP's right arm and the AP grabbed and restrained the resident's left wrist and put her other hand in the resident's face. The resident pushed the AP's hand away from her face and walked back toward the kitchen counter, then out of the dining room. The resident re-entered the dining room and followed the AP to another resident's table. The AP turned and pushed the resident away, causing the resident to stumble backward. The resident swatted at the AP and the AP again grabbed the resident's left wrist in restraint.

The AP was observed on the recorded video holding the resident in a bear hug. The AP's left arm was around the resident's back, and the AP was restraining the resident's arms at her side. The resident struggled to free herself as the AP forcibly walked the resident back toward the kitchen counter in a bear hug. The resident continued to struggle, and the AP could be seen holding the resident's left wrist with her right hand. During the struggle, the resident stumbled face first into the kitchen counter and then fell to the floor. A second staff assisted the resident off the floor and redirected her out of the dining room.

During interview a facility nurse stated she reviewed updates and notes when she returned to work after the weekend. According to the facility triage service, the resident had an incident of agitation, attacked a staff, and the resident was eventually redirected. The nurse reviewed dining room recorded video footage of the incident and stated she was disturbed by what she saw. The triage report and the video were not what was reported. The nurse stated after she investigated the incident, she determined the resident had a utensil in her hand which the AP ripped forcibly out of her hand, which agitated the resident. The resident walked up behind the AP, and the AP swung around with her arm out, which increased the resident's agitation. The AP forcibly grabbed the resident in a bearhug and began to drag the resident to the dining room counter. It appeared the AP pushed the resident into the counter and then the resident fell to the ground. Another staff came over to help and redirected the resident away from the dining room. The nurse stated when the AP was interviewed about the incident, she became defensive, denied the allegation, and continued to say the resident attacked her.

When interviewed, the AP denied the allegation.

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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: No, unable due to cognition.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and 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		

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
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		