Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL21410001M
Compliance #: HL21410002C

Date Concluded: February 9, 2022

Name, Address, and County of Licensee Investigated:
Sunrise of Roseville
2555 Snelling Avenue North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

Allegation(s): The alleged perpetrator (licensee (AP1)) neglected the resident when AP1 did not answer the resident's call light for 16 hours after a fall. It is also alleged that an alleged perpetrator (AP2) abused the resident when the AP licked the resident's ear, pinched the resident's neck, and fondled the resident.

Investigative Findings and Conclusion:
Neglect is substantiated. The call light report showed that on 36 occasions in two weeks, the resident's call light was activated, and no staff responded. Staff found the resident on the floor three times in the two-week period.

Abuse is inconclusive. A family member stated AP2 appeared to be inappropriately close to the resident when she was lying in bed and AP2's job did not include assisting with resident cares. AP2 denied abusing the resident and stated he was in the resident's room to pray with the resident, which was why he was so close to her.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility, observed staff/resident interactions, reviewed resident records, incident reports, work orders, call light logs, employee

training, personnel records, policies and procedures related to vulnerable adults, service plans, answering call lights, laundry, falls, and boundaries training. The investigator did not have access to the video of the resident's apartment.

The resident lived in the memory care unit for about two weeks after a hospital stay. The resident received services including assistance with morning activities of daily living, toileting two to four times per shift during the day and once overnight, incontinence care two to four times per shift, safety checks two to four times per shift, assistance to activities and meals, and physical assist of two persons for transfers.

A call light report showed the resident, or someone in the resident's apartment, used the call light three to 16 times per day during the resident's stay. The call light report showed on 36 occasions the resident's call light was pressed, it alerted staff pagers nine times with each call, and the staff never responded to the resident's call light.

The resident's progress notes indicated staff found the resident on the floor on three different occasions and the resident was unable to get up. The nurse assessed the resident for injury, staff monitored the resident, and the resident had no injuries from the falls.

During an interview a nurse supervisor stated when a resident pushed the call light it alerted on the staff pagers the name and apartment number of the resident. The staff then went to the resident and assisted them and then shut off the call light. The nurse supervisor stated if the staff did not shut off the call light, it alerted staff again with the name and room number every six minutes and after 45 minutes the call light would shut off. The nurse supervisor stated the facility identified call light response times as an area that could improve and was currently being worked on.

During interview a family member stated the resident knew how to use the call light and wore a pendant around her neck that she pushed when she woke in the morning so that staff would come help her get ready for the day. The family member said one time the resident had a fall the family saw on video, so they went to the facility, and still had to wait for a nurse to come. The family member stated several agency staff who were working shifts at the facility told her they did not have access to the call light system, and it alerted staff on another floor. The family member said that it always took a long time to get the resident help.

An incident report indicated the family expressed concern about the behavior of a staff member (AP2) that was observed on video from a camera in the resident's apartment.

AP2's personnel file indicated that AP2 worked at the facility for several years in the maintenance department and received training on vulnerable adults and boundaries.

During interview, a family member stated family put a camera in the resident's apartment and observed AP2 go into the resident's apartment. The resident was lying in bed and AP2 got near

her face. The family member stated she could not hear what AP2 said to the resident but AP2 appeared to 'nuzzle' the resident ear. The family member stated she heard the resident say "stop" or "that's enough" and found AP2's behavior odd.

During interview, AP2 stated he often met with residents in their apartments. AP2 stated he was familiar with the resident's hometown and often reminisced with the resident. AP2 stated on the day of the incident the resident was tearful and AP2 prayed with the resident. AP2 denied touching the resident inappropriately.

In conclusion, neglect was substantiated, and it was inconclusive whether abuse occurred.

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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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.
(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.
(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.

Vulnerable Adult interviewed: No, the resident had moved to another facility and was not able to interview by phone.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility began a quality improvement project for call light response, initially focusing on equipment.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Mental Health and Developmental Disabilities
The Office of Ombudsman for Long-Term Care
Roseville City Attorney
Ramsey County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21410	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ROSEVILLE	2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113

(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: #HL21410002C/#HL21410001M On January 26, 2022, 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 73 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL21410002C/#HL21410001M, tag identification 0460, 0650, and 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement an effective call light system for one of one resident (R1) reviewed for call lights, when multiple staff failed to answer R1's call light (that alerted staff for 45 minutes) on 36 occasions in a two-week period. Staff found R1 on the floor three times during the two-week period. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 460		

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0 460	Continued From page 2 Findings include: R1 moved into the facility on December 21, 2021, after a hospitalization for a fall and COVID-19. R1's diagnoses included cognitive impairment. R1's service plan dated December 21, 2021, indicated R1 received services from the licensee that included encouragement to ask for assistance to the bathroom, assistance to the bathroom (two to four times per shift, one time overnight, and as needed), incontinence care, and fall checks two to four times per shift and as needed. R1's progress note dated December 24, 2021, at 11:53 a.m. indicated R1 had a fall within the last day (unknown date and time) and had no obvious injury related to the fall. R1's progress note dated December 27, 2021, 16:42 (4:42 p.m.) indicated on December 27, 2021, at 12:00 p.m., a staff found R1 on the floor (unknown location). The progress note did not indicate whether R1 had an injury. R1's progress note dated December 30, 2021, at 11:54 a.m. indicated on December 28, 2021, (at unknown time) a staff found R1 sitting on the floor (unknown location). The progress note indicated R1 had no injury. R1's Alerts report (documentation of call lights) dated December 20, 2021, through January 6, 2022, indicated on the following dates and times R1's call light or personal help button was activated, announced nine times (45 minutes), and never responded to: December 21, 2021, at 5:20 p.m. (apartment call	0 460		

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0 460	Continued From page 3 light) and 7:36 p.m. (apartment call light), December 23, 2021, at 11:10 a.m. (bathroom call light) and 6:59 p.m. (apartment call light), December 24, 2021, at 1:01 p.m. (apartment call light) and 7:07 p.m. (apartment call light), December 25, 2021, at 9:31 a.m. (apartment call light) and 3:24 p.m. (personal help button), December 26, 2021, at 8:27 a.m. (apartment call light), 3:04 p.m. (apartment call light) and 7:15 p.m. (personal help button), December 27, 2021, at 6:55 p.m. (personal help button), December 28, 2021, at 9:05 a.m. (apartment call light), December 29, 2021, at 7:24 a.m. (personal help button), 7:44 a.m. (apartment call light), 8:09 a.m. (personal help button), 8:55 a.m. (personal help button), 1:30 p.m. (personal help button), and 6:42 p.m. (personal help button), December 30, 2021, 9:56 a.m. (apartment help button), 10:47 a.m. (apartment help button), 2:11 p.m. (personal help button), and 6:12 p.m. (personal help button), January 1, 2022, at 2:56 p.m. (personal help button), and 7:16 p.m. (personal help button), January 2, 2022, at 1:16 p.m. (apartment call light), January 3, 2022, at 12:30 p.m. (personal help button), 3:28 p.m. (personal help button), 6:08	0 460		

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0 460	Continued From page 4 p.m. (apartment call light), and 7:07 p.m. (personal help button), January 4, 2022, at 11:54 a.m. (personal help button), 6:11 p.m. (personal help button) and 7:14 p.m. (personal help button), January 5, 2022, at 7:04 p.m. (personal help button), January 6, 2022, at 9:43 a.m. (apartment call light) and 9:43 a.m. (bathroom call light). During an interview on February 8, 2022, at 2:45 p.m., resident care director (RCD)-D stated all resident apartments have a pull cord call light on the wall and in the bathroom. RCD-D stated some residents also have a personal help button on their wrist or around their neck. RCD-D stated R1 had a personal help button. RCD-D described when the call light or personal help button was activated an alert went to all staff pagers with the resident's name and apartment number. RCD-D stated the notification would repeat every six minutes until the staff went to the apartment, helped the resident, and shut it off. After nine alerts (45 minutes after the initial activation) to the staff pagers without a response, it would shut off. RCD-D stated she expected staff to respond to the call light/personal help button in a timely manner. During an interview on February 9, 2022, at 12:15 p.m., family member (FM)-F stated the staff working for the licensee told her that often the pagers did not work, and that the alert only went to the second floor, not the third floor where R1 lived. FM-F stated she did not believe that all staff were properly trained on use of the call light system.	0 460		

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0 460	Continued From page 5 The licensee did not provide a requested call light policy. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 460		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three	0 650		

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0 650	Continued From page 6 years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to conduct an annual performance evaluation of one of one employee (maintenance coordinator (MC-C)) reviewed for personnel files. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: MC-C's personnel files indicated the licensee hired MC-C on July 5, 2016, as maintenance coordinator to maintain a safe, clean, and comfortable environment, which included knowledge of plumbing, heating, air conditioning, electrical, mechanical, and equipment repair. MC-C's most recent annual performance evaluation dated February 28, 2019, provided no rating of MC-C's performance, but was signed on March 1, 2019. MC-C's performance note dated August 16, 2019, indicated MC-C's supervisor discussed concerns regarding review process and correct format to give constructive feedback. MC-C's performance counseling and improvement plan for corrective action dated January 10, 2022 indicated MC-C received a final	0 650		

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0 650	Continued From page 7 written warning for not being mindful of resident's rights, personal space, and being in close proximity to a resident without a mask on. During an interview on January 26, 2022, at 2:20 p.m., executive director (ED)-A verified that MC-C did not have a performance evaluation in the previous two years. During an interview on January 26, 2022, at 2:46 p.m., regional director of operations (RDO)-B stated all employees should have an annual performance evaluation and verified that MC-C did not. The Annual Performance Appraisals policy dated May 31, 2019, indicated employees received a performance appraisal at least annually, and more frequently when appropriate. TIME PERIOD FOR CORRECTION: 7 (Seven) Days	0 650		
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 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 residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include:	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 8 On January 26, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility 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		