Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL232179346M
Compliance #: HL232177104C

Date Concluded: January 2, 2024

Name, Address, and County of Licensee Investigated:
Regent at Burnsville
14500 Regent Lane
Burnsville, MN 55306
Dakota County

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

Evaluator's Name: Lissa Lin, RN
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 perpetrator (AP) abused a resident when he rough handled the resident during toileting.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Even though the resident had a red mark on his back, interviews produced conflicting information on several aspects of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident. The investigation included review of medical records, personnel records, policies and procedures and staff

schedules. Also, the investigator observed staff members provide personal cares, serve meals and clean resident rooms.

The resident lived in an assisted living facility with his wife. His service plan indicated he received help with dressing and toileting assistance of one staff member. The resident's diagnoses included hypertension, glaucoma and macular degeneration. The nurse assessed the resident as able to use a call pendant and makes his needs known. He had episodes of hallucinations and a decline in strength and endurance. He was able to stand with assistance of one staff member and use a walker for some walking. The resident recently began hospice. His wife did not receive assisted living services.

One night, the resident activated his call pendant for toileting assistance. The AP answered the call pendant, assisted the resident to the toilet and then back to his wheelchair and bed.

The following day the nurse received a report of a rough handling allegation. The nurse assessed the resident and observed a red mark on his back that measured six inches long by one inch wide along the spine. The nurse wrote the mark looked like a rug burn. The nurse interviewed the resident and his wife. The resident said during the previous night, the male staff person sat him down on the toilet so hard he hit his back and was "thrown around like a sack of potatoes." The resident told the nurse he was not sure who the staff member was by name but described him.

During an interview, the AP said he did not handle the resident roughly. He answered the call light, introduced himself and asked what he could do to help. The AP said he had no difficulties transferring the resident from his wheelchair to the toilet. The AP said the resident did not yell or complain about his back during the toileting transfer. The AP said the resident's wife talked to him most of the time while he transferred the resident. Then she went to the bedroom across the hall, so she would have heard if there was a problem. The AP said he waited outside the bathroom to give the resident privacy and asked him several times if he was ok. The resident said he was ok each time. When the resident finished in the bathroom, the AP said he transferred him back to the wheelchair and to his bed. The resident and his wife thanked the AP by name when he left. The AP said he was shocked when the nurse called him the next day and said he had been rough with the resident and bruised him. The AP was placed on suspension pending investigation.

During an interview, the nurse said she interviewed the resident and his wife a few times and they described the incident the same way each time. When she called the AP, the nurse said he told her he performed the cares correctly and did a good job. Hallway camera footage showed the AP was the only male staff member to enter the resident's room during the overnight shift.

The resident and his wife declined recorded interviews. The resident said the male staff person did not want to be there or help him, but he did not know his name. The resident's wife said she thought the incident occurred several days earlier than reported.

Record review indicated several days earlier, another male staff member answered the resident's call pendant during the overnight shift and initially refused to provide toileting cares because he thought the resident did not receive any assisted living services. The staff member eventually helped the resident to the toilet. The resident's wife reported the interaction to the nurse and staff were re-educated on the various service packages residents might have. There was no allegation of rough handling.

In conclusion, the Minnesota Department of Health determined abuse 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:
(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;

Vulnerable Adult interviewed: Declined a recorded interview.
Family/Responsible Party interviewed: Declined a recorded interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility conducted an internal investigation, assessed the resident and the AP is no longer employed by 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
	23217	A. BUILDING: _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT AT BURNSVILLE	14500 REGENT LANE BURNSVILLE, MN 55306

(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: #HL232173882C/HL232177306M, HL232171126C/HL232175923M, and HL232177104C/ HL232179346M. On December 5, 2023 through December 6, 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 139 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL232173882C/HL232177306M#, tag identification 470.	0 000	Minnesota Department of Health is documenting the State 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to ensure the facility could respond promptly and effectively to individual resident emergencies when developing the licensee staffing plan. Two of two memory care residents, (R2 and R5) choked during meals when one staff was assigned in the dining room which required staff to perform the Heimlich maneuver, yet also try to contact other staff in the facility to call for emergency assistance or	0 470		

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0 470	Continued From page 2 services. This had the potential to affect all residents. 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, but was not likely to cause serious injury, impairment, or death) 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 of the residents). The findings include: R2 R2 lived in the memory care unit. Her diagnoses included malignant salivary gland cancer, brain cancer and dementia. R2's service agreement dated July 10, 2023, indicated she received assistance with activities of daily living. There was a delegated unlicensed personnel (ULP) task to document if R2 ate breakfast and add an unscheduled service for times she had breakfast. R2 had a regular diet with thin liquids. R2's progress notes dated July 10, 2023, at 12:29 p.m., indicated the hospice nurse was at facility to admit R2 to hospice. At 6:54 p.m, director of health services (DHS)-A arrived at R2's apartment after getting called to the memory care unit. R2 was seated in her wheelchair, slumped over with no audible or palpable apical pulse, no respiratory effort. Oximeter reading was 66% and falling. Emergency medical services (EMS) arrived, given report R2 was DNR (do not resuscitate), was just evaluated for hospice and would have been admitted to hospice. R2's time of death noted as 12:45 p.m.	0 470		

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0 470	Continued From page 3 The licensee "Internal Investigation of Incident" dated July 10, 2023, at 12:38 p.m., indicated R2 was suspected of choking due to noted distress while eating lunch in the common area. ULP-G performed the Heimlich maneuver until R2 slumped over with little response. ULP-G then stopped performing the Heimlich. R2 was eating lunch around 12:20 p.m.; she had soup and her entree. R2 noted to be in distress at 12:35 p.m. and ULP-G started Heimlich. ULP-G also made calls to nursing and front desk at 12:38 p.m. Staff arrived in unit at 12:40 p.m. ULP-G left unit at approximately 12:42 p.m. with no report given to care team. Review of a licensee untitled, undated document indicated camera footage was reviewed and ULP-G performed the Heimlich maneuver until R2 became unresponsive. ULP-G called nursing and front reception to get help but she was crying and unable to communicate what was needed. Nursing staff and other staff arrived at the unit. During an interview on January 5, 2024 at 9:18 a.m., ULP-G said the day R2 choked was the first time the nurse was not close by. ULP-G said she was reheating R2's soup, she began eating soup and bread, when one of the residents said R2 needed help. ULP-G said she began the Heimlich, tried to move R2 in her wheelchair with her elbows and call the front desk for help. ULP-G dropped the phone twice trying to call. ULP-G said she was crying and told the front desk staff to send help. ULP-G said she was trained to do the Heimlich and did her best. During an interview on January, 2024 at 8:32 a.m., registered nurse (RN)-K said she was orienting a new staff member when the regular desk phone rang. It was around noon and	0 470		

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0 470	Continued From page 4 whoever called was crying or laughing "weird". RN-K said hello a few times with no answer, so she hung up. She told the new staff member someone must have "butt dialed" her. RN-K said front desk staff called her and said she had to go to memory care right away but did not give a reason why. RN-K said when she arrived at the memory care unit ULP-G was on the floor crying and hysterical and then ran out of the unit. R5 R5 lived in the memory care unit. Her diagnoses included unspecified dementia. R5's service plan signed December 1, 2023, indicated since April 21, 2023 she received daily meal monitoring by staff to support adequate intake. R5 had a regular diet. A progress note dated November 28, 2023, at 1:06 p.m., indicated an emergency page went out from memory care that nursing was needed right away. R5 choked on pizza crust during lunch. ULP-J performed the Heimlich maneuver and with the second abdominal thrust the crust was expelled. EMS arrived to assess R5 and determined she did not need to go to the emergency room. The nurse assessed R5 and contacted her provider and family. Staff continued to monitor R5 as she ate dinner without incident. During an interview December 5, 2023, at 10:55 a.m., ULP-J said she is regularly scheduled to work in memory care and the staff ratio is one staff for five residents. ULP-J said she performed the Heimlich on R5 during the past week when she choked on a pizza crust. ULP-J said it was scary but she was trained to do the Heimlich, then called the manager. A policy titled Staffing, dated March 28, 2023,	0 470		

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0 470	Continued From page 5 indicated the staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week and will be adequate to address the residents' scheduled and reasonable unforeseeable unscheduled needs given the physical layout of the facility. A policy titled Direct-Care Staffing Plan, dated April 6, 2023, indicated the adequate number of staff is determined by the scheduled services in independent and assisted living in each memory care suite at a 1:5 staffing ratio, and care suites at a staffing ratio of 6 or 7 residents. A policy titled Food and Nutrition Services, revised January 16, 2023, did not address mealtime staffing ratios. TIME PERIOD TO CORRECT: Seven (7) Days	0 470		