



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL287018364M
Compliance #: HL287015565C

Date Concluded: December 14, 2023

Name, Address, and County of Licensee

Investigated:

Founders Ridge
6600 Auto Club Road
Bloomington, MN 55438
Hennepin County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Not Substantiated

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 threatened to hit the resident when the resident was kicking and striking out at the AP.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. While the AP communicated in an unprofessional manner with the resident, the resident was not harmed, and this was an isolated incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the staffing agency the facility was using to staff the facility. The investigation included review of resident and employee records, and facility policies and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with mobility and incontinence assistance. The resident's assessment indicated the resident often refused care and staff assistance.

During an interview, unlicensed personnel (ULP) stated when she and the AP were providing incontinence care for the resident, the resident was combative, kicking, and swinging his arms. The AP responded and said to the resident "I will hit you as hard as you hit me." The ULP told the AP he could not say or do that to the resident. The ULP stated the resident continued to be combative but did not appear to be fearful after the statement was made. The ULP stated she checked on the resident later in the evening and the resident was sleeping and did not appear to be affected by the incident.

During an interview, the AP denied he threatened to harm the resident. The AP stated a co-worker may have misunderstood his intent when the AP joked around with residents.

During an interview a family member stated the resident was combative when staff tried to help him. The family member stated she did not have any concerns about the staff or the care the resident was receiving.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.

Vulnerable Adult interviewed: No, Resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

Staff re-educated to treat residents with courtesy and respect.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/18/2023
NAME OF PROVIDER OR SUPPLIER FOUNDERS RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 AUTO CLUB ROAD BLOOMINGTON, MN 55438			
(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 On October 18, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL287015565C/HL287018364M. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE