MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Augustana Emerald Crest Burnsville

Facility Address:
451 East Travelers Trail

Facility City:
Burnsville

State: Minnesota | **ZIP:** 55337 | **County:** Dakota

Report Number:
HL29326001 and HL29326002

Date of Visit:
January 4, 2017

Time of Visit:
8:30 a.m. to 12:30 p.m.

Date Concluded:
September 12, 2017

Investigator's Name and Title:
William Nelson, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a resident was abused when staff/alleged perpetrator (AP) slapped the resident in the face. The resident's face was initially reddened but later resolved. Review of facility video showed the AP slapped the resident.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, abuse is substantiated. The alleged perpetrator (AP) slapped the client on the face. The AP and the client were identified on the facility video recording by supervisory staff.

The client received services from the provider, which is licensed as a comprehensive home care provider. The client's diagnoses included Alzheimer's disease. The client required assistance with all cares. Due to the advanced dementia, the client required verbal cues to complete activities of daily living. The client routinely woke up at 10:30 p.m. and walked around the dining room area, sat at different tables, and then would request a snack and go back to bed.

On the night of the incident, the client had gone to bed at approximately 8:30 p.m. The client got up at approximately 10:30 p.m., walked around the dining room, and sat at a table. A review of the facility video recording of the date of the incident showed that at approximately 11:20 p.m. the client was walking around the dining room, and the AP came into the room and shut the lights off. The client said, "Turn them on". The AP directed the client to go to the client's room and go to bed, while pointing down the hallway. The client began pounding on the table and saying something. The AP then walked toward the client, and with his/her right hand, slapped the left side of the client's face. The client began yelling, "Why did you slap me, he slapped me, why did you slap me?" The AP walked towards the client as the client continued to yell, telling the client to go to the client's room. A second staff member came into the dining room and separated the client and the AP, and brought the client to the client's bedroom.

The police report indicated an individual that was in an adjacent room to the incident heard loud voices and heard what s/he described as a loud slap. The individual was in the next room and stated that s/he did not see the AP slap the client. The individual then went into the dining area to see what was going on. When s/he entered the room, s/he saw the AP and the client "in a tussle" and separated them. The individual told police that the AP denied hitting the resident; however s/he reported the incident to the director of the facility that night. The individual declined to be interviewed during the investigation.

The AP declined to be interviewed during the investigation.

The facility terminated the AP's employment. The AP was convicted of Assault of a Vulnerable Adult.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The alleged perpetrator is responsible for the abuse. Although the facility had policies in place to address maltreatment of vulnerable adults, the alleged perpetrator slapped the client.

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.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) – Compliance Met
The facility was found to be in compliance with State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"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....

(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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Service Plan

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Zero

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: Did not recall the incident

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: One

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ◉ No ○ N/A Specify: Attempted, refused

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Dignity/Privacy Issues

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Burnsville Police Department

Dakota County Attorney

Burnsville City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 20, 2018

Ms. Julianne Fries, Administrator
Augustana Emerald Crest Burnsville
451 East Travelers Trail
Burnsville, MN 55337

RE: Complaint Number HL29326001 and HL29326002

Dear Ms. Fries :

On January 8, 2018 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on September 13, 2017. **At this time, these correction orders were found corrected.**

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Dakota County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 70151660 0000 4179 7788

September 13, 2017

Ms. Julianne Fries, Administrator
Augustana Emerald Crest Burnsville
8150 Bavaria Rd.
Victoria, MN 55386

RE: Complaint Number HL29326001 and HL29326002

Dear Ms. Fries :

A complaint investigation (#HL29326001 and HL29326002) of the Home Care Provider named above was completed on September 13, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Matthew Heffron

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Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
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MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Dakota County Adult Protection
Office of Ombudsman
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29326	A. BUILDING: _____ B. WING _____	C 09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA EMERALD CREST BURNSVILLE	451 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 A complaint investigation was conducted to investigate complaint #HL29326001 and HL29326002. The following correction order is issued.	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/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that one of one clients (C1) was free from abuse, when a staff person was observed to slap the client across the client's face. This practice resulted in a level 3 violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury impairment, or death) and is issued at an isolated scope (one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: C1's medical record was reviewed. C1 resided on memory care unit and had a diagnosis of dementia, anxiety and insomnia. An Individual Abuse Prevention Plan dated 12/20/2016 identified C1 as oriented to self and family, confused to place and time. C1 had very poor short term memory. C1 ambulated without the use of assistive devices. C1 enjoyed socializing with others during group activities. C1 spoke clearly but had difficulty with word finding occasionally. A progress note dated 12/19/2016 indicated that the director of the program received a report of suspected abuse of C1 during the night shift. The reporter gave an estimated time and the director	0 325		

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0 325	Continued From page 2 and nurse reviewed video footage of the security tapes. The video tape recorded at 11:20 p.m. on 12/18/2016 C1 was walking around the dining room and became upset when Nursing Assistant D (NA-D) started turning off lights in the dining area. C1 began yelling and slamming her hands on a table. NA-D walked up to C1 and told her to go to bed. NA-D then continued to turn off lights and C1 continued yelling and hitting the tables with her hands again. NA-D walked up to C1 and slapped her across the left side of her face. NA-D then told her to go to bed. NA-E entered the dining area from another room and separated NA-D and C1 and brought C1 to her bedroom. A progress noted dated 12/20/2016 indicated that an RN-A assessed C1 and C1 denied pain and C1 did not recall the incident. RN-A noted a small area above C1's lip appeared to be developing a bruise. An interview on January 4, 2017 at 11:00 a.m. of Registered Nurse A (RN-A) found that C1 would go to bed around 8:30 p.m. and get up at 10:30 p.m. or 11:00 p.m., walk around the dining area and ask for a snack. The staff were aware of this behavior and would give C1 a snack. After the snack C1 would ask where his/her bed was located, staff would bring C1 to bed and C1 would go back to bed. Review of the video of the date of the incident showed that at approximately 11:20 p.m. C1 was walking around the dining room, and NA-D came into the room and shut the lights off. C1 said "turn them on" and NA-D directed C1 to go to the C1's room and go to bed, while pointing down the hallway. C1 began pounding on the table and saying something. NA-D then walked toward C1,	0 325		

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0 325	Continued From page 3 and with his/her right hand, slapped the left side of C1's face. C1 began yelling, "why did you slap me, he slapped me, why did you slap me." NA-D walked towards C1 as C1 continued to yell, telling C1 to go to C1's room. A second staff member came into the dining room and separated C1 and NA-D, and brought C1 to his/her bedroom. Review of the police report indicated NA-E stated that s/he did not see NA-D slapping the client. NA-E was in the next room and heard loud voices and heard what s/he described as a loud slap. NA-E then went into the dining area to see what was going on. When NA-E entered the room s/he saw NA-D and C1 "in a tussle" and separated them. NA-E stated to police that NA-D denied hitting the resident, however s/he reported the incident to the director of the facility that night. The witness declined to be interviewed during this investigation. TIME PERIOD FOR CORRECTION: 7 days.	0 325		