Protecting, Maintaining and Improving the Health of All Minnesotans

Health Regulation Division
Investigative Public Report

Maltreatment Report #: HL29718012M

Date Concluded: November 29, 2021

Name, Address, and County of Facility Investigated:
The Legacy of St. Anthony
4601 Excelsior Boulevard Suite 650
St. Louis Park, MN 55416
Hennepin County

Name, Address, and County of Housing with Services location:
River Oaks of Anoka
910 Western Street
Anoka, MN 55303
Anoka County

Facility Type: Home Care Provider

Investigator Name:
John Sheridan-Giese, RN, Rapid Response Evaluator

Finding: Substantiated, individual responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) physically abused the resident when she hit the resident on top of his head and kicked his shin.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The investigation determined the AP's actions did not cause physical abuse however the AP's actions did cause emotional abuse. The AP emotionally abused the resident when she grabbed at the top of the resident's head with her fingers. A day later while on an outing at a retail store the AP motioned to kick the resident's shin.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of video surveillance. The investigation included a review of the resident's medical record.

The resident's diagnoses included depression and vertigo (a sensation of dizziness and loss of balance). The resident's service plan indicated the resident required assistance with wellness checks and meals. The resident's progress notes indicated the resident used a two wheeled walker for ambulation.

The facility's surveillance video indicated the resident was sitting at a table participating in an activity with other residents. The AP walked up behind the resident and touched the top of the resident's head with her right hand. The AP used her fingers of her right hand and made a grabbing motion twice.

On the next day while on an outing at a retail store, the retail store's surveillance video recorded the resident sitting on a bench inside the store's front entrance. The same recording showed the standing and facing the resident. The same recording showed the AP walk backwards one step, then walk forward toward the resident, and motion to kick the resident's left shin with her right foot.

During an interview, the resident stated he was participating in an activity when the AP approached him and suggested he do the activity in a different way, but the resident declined. The resident stated the AP slapped her fingers on top of his head. During the same interview, the resident stated another incident occurring the next day at a retail store while he and the AP were waiting for the facility bus when the AP kicked him in the shin. The resident stated the AP acted aggressively and, after these two incidents, he was afraid the AP may hit him, break his glasses, or knock him down and hurt him.

During an interview, the AP denied hitting the resident on the head but stated during the activity she may have touched the resident's head. The AP denied kicking the resident but stated she motioned to kick the resident with her foot at the retail store. During the interview, the AP stood up, walked around the interview table, and performed a kicking motion with her right foot to demonstrate what took place. The AP stated motioning to kick the resident was not a good idea and it was not appropriate.

During an interview, the executive director (ED) stated when he originally asked the AP about the resident's concern regarding AP touching his head, the AP told him she placed her hands on the resident's shoulders and not the resident's head. The ED stated when he viewed the facility's surveillance video of the event, he felt sick because the facility surveillance video showed the AP touching the resident's head not his shoulders and he could not believe she put her hands on the resident anywhere. The ED stated when he asked about what happened at the retail store, the AP denied kicking the resident at the store.

In conclusion, emotional 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 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: Yes
Family Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility suspended the AP pending investigation.

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.

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
Anoka Police Department
Anoka County Attorney’s Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29718	A. BUILDING: _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST ANTHONY	2540 KENZIE TERRACE ST ANTHONY, MN 55418

(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 The Minnesota Department of Health conducted a maltreatment investigation, in accordance with Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minnesota Statute § 626.557. The Minnesota Department of Health issued a correction order pursuant to the investigation. INITIAL COMMENTS: On October 6, 2021, the Minnesota Department of Health conducted a maltreatment investigation of complaint #HL29718012M. At the time of the investigation, there were #67 clients receiving services under the comprehensive license The following correction order is issued for #HL29718012M, tag identification 0325.	0 000		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) 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 interviews and document review, the facility failed to ensure one of one clients reviewed (R1) reviewed was free from maltreatment. R1 was emotionally abused.	0 325		

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0 325	Continued From page 1 Findings Include: On October 6, 2021, the Minnestota Department of Health (MDH) issued a determination that abuse occurred to R1, and an individual staff person 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.	0 325		