

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306012380M
Compliance #: HL306011431C

Date Concluded: May 21, 2024

Name, Address, and County of Licensee

Investigated:

Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379
Benton County

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

Evaluator's Name: Erin Johnson-Crosby, 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) abused the resident when the AP was rough and aggressive with the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. There was not a preponderance of evidence to determine that abuse occurred or whether the AP's actions met the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's record, facility internal investigation documentation, incident reports, personnel files, staff schedules, and related facility policies and procedures. At the time of the onsite investigation, the investigator observed resident cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and dementia with behavioral disturbance. The resident's service plan included assistance with bathing, dressing, grooming, toileting, behavior management for agitation, medication management, and safety checks. The resident's assessment indicated the resident was severely cognitively impaired and wandered into other resident's rooms. The assessment also indicated the resident was at risk for abuse due to cognitive impairment. The resident's record did not indicate any evidence of injuries.

Complaint documents indicated facility management was informed by a witness that on two occasions, a facility staff member/alleged perpetrator (AP) was rough with the resident while providing cares. Facility internal investigation notes indicated multiple staff were interviewed and denied knowledge of the AP mistreating residents.

During investigative interviews, one facility unlicensed personnel (ULP) stated that the AP did not like when the resident was up at night and wanted the resident to go back to bed. The ULP stated that the AP was rough, aggressive, and that the AP yanked and pulled the resident's pants down if the resident resisted toileting assistance. The ULP stated that the AP continued to provide care despite the resident refusing and being resistive to care.

During multiple interviews, other staff members stated they had never witnessed the AP, or any other staff members, mistreat any residents. The staff members indicated that if they had concerns with a staff member that they would immediately report their concerns to facility management.

During an interview, the AP denied grabbing, pulling, yanking, on the resident while performing cares. The AP stated that if the resident required incontinent assistance, she could not just leave the resident in a soaked incontinent product in bed, but she never forced the resident to do anything. The AP stated that if the resident resisted care, she would first attempt to calm the resident before providing care.

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, unable due to cognitive impairment.

Family/Responsible Party interviewed: Attempts to contact were unsuccessful.

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility reported the incident to the state agency, completed an internal investigation, and the AP is no longer employed at 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2024
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NAME OF PROVIDER OR SUPPLIER SUMMIT RIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379
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(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	<p>Initial Comments</p> <p>On March 12, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306012380M/HL306011431C. No correction orders are issued.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	