*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306476284M
**Compliance #:** HL306479469C

**Date Concluded:** March 19, 2025

**Name, Address, and County of Licensee Investigated:**
Inver Glen Senior Living
7260 South Robert Trail
Inver Grove Heights MN, 55077
Dakota County

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

**Evaluator's Name:** Kris Detsch, 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 AP abused a resident when she forced her to shower against her will. The resident had bruising on her wrists and forearms.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was not substantiated. Although the resident's behavior indicated she did not want to shower, she had a history of yelling out and resisting cares. The resident had dementia (memory loss) and did not have insight into her care needs. The actions of the AP did not meet statute requirements for abuse, and no harm occurred to the resident. Providing a shower was in the best of interest of the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice staff. The investigation included review of the resident's medical records, hospice records, physician records, facility internal investigation, facility incident reports, personnel files, and related facility policy and

procedures. Also, the investigator toured the facility and observed facility staff provide personal cares and repositioning.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mood disorder, cognitive impairment (memory loss), diabetes, and coronary artery disease (heart disease). The resident's service plan included assistance with bathing, dressing, oral care, toileting, grooming, medications, and meals. The resident's nursing assessment indicated staff members needed to anticipate her needs because she had memory loss. The resident was dependent upon staff members for mobility and required a wheelchair. The assessment indicated the resident had agitation, delusions, hallucinations, verbal aggression toward staff and others. The resident was incontinent (no control) of bowel and bladder. The assessment indicated the resident had ecchymosis (bruising) to her lower extremities.

Through investigative process, it was determined there were two separate concerns regarding this incident. The first, was bruising of the resident's skin, found to be a separate issue from second concern regarding the resident's shower.

**First Concern:**
During an interview, a hospice nurse said she observed small bruises on the resident's wrists consistent with "thumb prints." The hospice nurse said she believed this bruising was consistent with caregivers pulling on the resident's arms to try to get her to stand. The hospice nurse said the resident never complained of pain, and she did not observe other skin injuries such as skin tears or swelling. The hospice nurse said she told the nurse manager about these bruises and the nurse manger told her she would re-educate their caregivers how to transfer the resident. The nurse manager said the bruises did resolve.

During an interview, a nurse manager said hospice staff informed her the resident had bruising on her wrists, so she observed the bruising, and it looked consistent with a "thumb print" as if someone pulled the resident up by her wrists. The nurse manager said she spoke to all the staff who provided care to the resident about how to safely transfer her; this included the AP.

During an interview, the AP said could not stand on her own and she was dependent upon staff for mobility. At times, the resident required multiple staff to stand her, or even use a mechanical lift. The AP said because the resident had memory loss, she did not use the call light and would hit the wall next to her bed or hit the wheelchair and she had bruising on her hands and legs.

The MAR indicated the resident received two blood thinning medications daily, putting her at an increased risk of bruising.

Physician visit notes indicated the resident's skin was thin and atrophic (loss of thickness) with ecchymosis on her forearms.

**Second Concern:**
During an interview, the hospice nurse said, she received a call from the hospice aide who told her the AP was weak and confused and not safe to get into the shower. The hospice nurse then told the hospice aide to give the resident a bed bath. Shortly after, the hospice aide called the hospice nurse back and said the AP "forced" the resident to take a shower and the resident screamed for the AP to "get away." The hospice nurse said the hospice aide did not provide further description of the incident. The hospice nurse said this behavior was not unusual for the resident, but the AP should not have showered the resident.

During an interview, the manager said she received a call from a hospice nurse who told her the AP was "forcing" the resident to shower. The nurse manager said she was not at the facility when this occurred, so she called a nurse who was at the facility and had her go to the resident's room. The manager said when she arrived at the facility, the AP completed the resident's shower and dressed her. The manager said the resident appeared to be free from distress or injury. The manger said generally the hospice aide calls the facility prior to her arrival and tells the staff to give the resident an anti-anxiety medication prior to the hospice aide providing a shower, but this did not occur. The nurse manager said typically the hospice aide would tell them the resident refused a shower, so the facility staff would end up giving her the shower. The nurse manger said the resident could be "feisty" and her typical behavior included yelling and screaming. The nurse manager said memory care residents who have behaviors and incontinence cannot sit in urine; staff must change them and get cares completed.

During an interview, a facility nurse said she worked at the time of the incident and received a call from the nurse manager who asked her to check on the resident. The nurse said when she went into the room, the resident was out of the shower, and the AP was getting her dressed. The resident was smiling and appeared to be her normal self. The nurse asked the AP about the resident's screaming and the AP told her the resident always screamed getting into the shower but was fine once she was in there. The nurse said she did not see anything unusual and was confused about what the concern was. The nurse said the AP was a fantastic caregiver.

During an interview, the AP said the hospice aide did not call the facility prior to her arrival, so the resident did not receive medication prior to the shower. The AP said the hospice aide told her the resident refused to shower. The AP said the overnight shift told her the resident had a large incontinent bowel movement, therefore the resident needed a shower. The AP said the resident also soiled her bedding with stool. The AP said she told the hospice aide she would help her give the resident a shower. The AP said she got a mechanical lift to get the resident out of bed, while the hospice aide was in the room watching her. The AP said the hospice aide left the room when the resident sat in the shower chair. The AP said the resident screamed at her to leave her alone during the transfer but stopped screaming once the shower started. The AP said the resident's behavior was not unusual. The AP said she washed the resident and got her dressed. The AP said the resident could not stay in bed because the bedding had stool on it, and she did not want the resident to get an infection. The AP said after the incident the nurse manager told her to make sure to give the resident medication prior to her showers. The AP

said the hospice aide accused her of abuse because she did not like her. The AP said the hospice aide often skipped resident showers, but residents only received one shower a week, and she wanted the resident to be clean.

The resident's medication administration record (MAR) indicated the resident received antibiotic medication for a urinary tract infection approximately three weeks prior to the incident. The MAR indicated the resident received scheduled (routinely given) psychotropic medication (medications affecting the brain and the central nervous system which alter mood and behavior).

The resident's progress notes indicated a hospice physician ordered an additional psychotropic medication for the resident approximately two weeks after the shower incident.

The hospice aide did not respond to requests for interview.

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. Deceased.

**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
The facility re-educated staff members on safe transfers and behavior management.

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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 |
|---|---|---|---|
| | 30647 | A. BUILDING: _____ B. WING _____ | C 02/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INVER GLEN SENIOR LIVING | 7260 SOUTH ROBERT TRAIL INVER GROVE HEIGHTS, MN 55077 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>HL306479469C/HL306476284M.<br><br>On February 26, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 97 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for HL306479469C/HL306476284M, tag identification 730. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 730 SS=D | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the | 0 730 | | |

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| 0 730 | Continued From page 1<br>following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution; | 0 730 | | |

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| 0 730 | Continued From page 2<br><br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure resident records had the required content including documentation of incidents involving the resident, assessment of injuries, and actions taken in response to the needs of the resident for one of one resident (R1) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when 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).<br><br>The findings include:<br><br>R1 admitted to licensee for diagnoses including altered mental status, diabetes, and coronary artery disease. R1's service plan dated February 26, 2025, indicated she required assistance with toileting, medications, showers, housekeeping, and laundry. The service plan indicated R1 required hospice care.<br><br>R1's hospice agency provided the licensee documentation notes after each visit. The visit notes included the following: | 0 730 | | |

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| 0 730 | Continued From page 3<br><br>-September 6, 2024, indicated R1 had bilateral bruising on her upper and lower extremities. The notes indicated R1 denied pain and appeared comfortable.<br><br>-September 20, 2024, indicated R1 had "multiple" bruises on both forearms/wrists. The note indicated the licensee should ensure they provide gentle transfers to avoid bruising or pain.<br><br>-October 1, 2024, indicated R1 had "new bruising" noted on her left hand, wrist, forearm.<br><br>R1's progress notes dated April 1, 2024, through October 18, 2024, indicated there were three documentation entries form nursing staff in the month of September 2024, however none of the entries indicated R1 had bruising. There were two documentation entries from nursing staff in the month of October 2024, and none of the documentation indicated R1 had bruising.<br><br>On February 26, 2025, at 11:08 a.m., the surveyor requested R1's incident reports. The surveyor received an incident report dated November 23, 2024. This incident report indicated R1 fell. No further incident reports provided.<br><br>The licensee provided a one-page document, no title, but director of nursing (DON)-A identified the document as her internal investigation regarding R1's bruising and an incident regarding R1's shower. The document contained written notes by DON-A, but the document was not part of R1's clinical record. The document indicated on September 27, 2024, a hospice nurse went into the nurses office and showed them bruising on R1's wrist. The bruising was consistent with thumb prints. DON-A's notes indicated she | 0 730 | | |

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| 0 730 | Continued From page 4<br><br>educated staff members on how to properly transfer R1. DON-A's notes indicated unlicensed personnel (ULP)-C said she grabbed R1's wrists when assisting her to grab the grab bars by the toilet.<br><br>On September 30, 2024, the hospice nurse showed DON-A a picture of R1's bruise to her right forearm, consistent with a thumb print. DON-A's notes indicated she spoke to ULP's about how to complete safe transfers and encouraged them to use an E-Z stand (mechanical lift). DON-A's notes indicated R1 took blood thinning medication. On October 2, 2025, DON-A's notes described events when a hospice caregiver observed ULP-C "force" R1 to shower. DON-A provided education to ULP-C.<br><br>R1's clinical record lacked indication staff members monitored these bruises, or observed for bruising considering her blood thinning medication, fall history, and agitation.<br><br>On February 26, 2025, at 2:08 p.m., DON-A said she talked with hospice staff about the bruising, but did not do an incident report, or further documentation regarding these bruises. DON-A said staff members should notify the nurses if they notice bruising, or anything unusual. DON-A said the licensee does not compete formal "skin assessments", and there was no formal documentation system for "monitoring" resident's skin. DON-A said ULP's should inform the nurses if they observe a skin issue.<br><br>The licensee's policy titled, Resident Record-Documentation, dated August 1, 2021, indicated the licensee would document important and pertinent information relating to each resident. | 0 730 | | |

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| 0 730 | Continued From page 5<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |