

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307511543M

Date Concluded: May 14, 2025

Compliance #: HL307512444C

Name, Address, and County of Licensee

Investigated:

The Commons on Marice
1380 Marice Drive
Eagan, MN 55121
Dakota County

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

Evaluator's Name: Holly German, 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 perpetrators (AP)-1 and AP-2, who are administrative staff at the facility, abused the resident when they secluded her from visiting family member (FM)-1.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined was not substantiated. AP-2 completed a trespass order on FM-1 for the safety of staff and residents. FM-1 was verbally and physically aggressive towards facility staff on multiple occasions. FM-1 was able to see the resident by arrangement of off-site visits. The investigation did not reveal evidence of negative effects to the resident related to the change in visit frequency of FM-1. Additionally, during the investigation, AP-1 was accused of preventing the resident from moving to another facility by telling the prospective facility lies, resulting in the facility not accepting the resident for placement. Evidence showed AP-1 participated in providing the other facility records to evaluate placement.

The investigator conducted interviews with facility staff members, including administrative staff, unlicensed staff, and nursing staff. The investigator contacted a licensed social worker, family members, and the resident's legal guardian. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions and resident cares while on site.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance and anxiety. The resident's service plan included assistance with eating, dressing, bathing, medication administration and transfers. The resident's assessment indicated the resident was dependent on the use of a wheelchair and was alert but confused.

A facility provided document indicated a no trespassing order was issued to FM-1 seven months prior to the investigation. The order indicated the FM-1 could not enter the land of the facility for one year from the issued date.

A family provided email correspondence indicated AP-1 contacted FM-1 one month prior to the trespass order requesting a sit-down meeting to discuss concerns the facility had regarding the actions of FM-1 that made staff feel uncomfortable. The email also stated the facility would like to assist with finding alternate placement to a different facility for the resident. The email indicated the facility had trespassed FM-1 from the facility.

A nurse's note indicated FM-1 entered the facility with a friend and was heading towards the elevator when she was intercepted by AP-2. AP-2 reminded FM-1 of the guidelines in place for visitation, and FM-1 became upset and waived papers in AP-2's face. FM-1's friend attempted to calm her down. The note indicated FM-1 stated she was not going to follow the guidelines.

A nurse's note indicated the resident's legal guardian instructed AP-1 to remove a camera from the resident's room that FM-1 had placed.

Medical provider notes did not indicate any concern or change in the resident during the provider's monthly visits after the trespass order was in place.

During an interview, AP-1 stated FM-1 had been the resident's guardian prior to the resident's spouse pursuing a third-party guardian due to family disagreements. AP-1 stated FM-1 was angry and unpredictable. AP-2 initiated a trespass order on FM-1 due to an incident when FM-1 aggressively lunged at AP-2. AP-1 stated the facility did not want to have to do a trespass order on FM-1 but had the duty to protect everyone. AP-1 stated there was further issues with FM-1 once the trespass order was in place. AP-1 stated FM-1 did not follow the order and continued to enter the building. AP-1 stated the resident continued to have visits with her family including FM-1 via home visits that were set up by family. AP-1 stated she noted a very positive change in the resident since the trespass order had been in place. The resident improved her self-feeding

skills, goes to all activities, and was more vocal than before. AP-1 stated the staff did not note any negative changes in the resident since the trespass order was placed on FM-1. AP-1 stated she became aware of the resident referral to another facility when RN-2 presented to her office after she had completed an assessment on the resident. AP-1 stated RN-2 requested the resident's medication list, face sheet and last six months of progress notes, which she provided to her. AP-1 stated she and RN-2 discussed the resident's level of care and service plan. AP-1 stated as RN-2 looked through the resident's progress notes, she stated she had concerns about FM-1. AP-2 stated she told RN-2 things have been better with the legal guardian in place.

During an interview, AP-2 stated there had been several conversations with FM-1 regarding FM-1's interference of the care of the resident and other facility residents. AP-2 stated FM-1 force fed the resident and gave other residents regular water who required thickened liquids. AP-2 stated he had to call the police on FM-1 when she came after him. AP-2 stated FM-1 did not think the trespass order had any value as she continued to try to enter the facility. AP-2 stated staff were directed by him to call the police if FM-1 entered the building, and there was an incident when staff began to call 911 on FM-1. FM-1 grabbed the phone from the staff member and hung up the call. AP-2 stated the resident, and her family could have visits off the property of the facility, and the facility staff prepared the resident to be ready for the visits. AP-2 stated there was a positive change noted with the resident after the trespass order was in place. AP-2 stated the resident was now on the verge of graduating from hospice services, was gaining weight, and gaining self-feeding independence. AP-2 stated having to complete a trespass order was not what they wanted to do, but felt it was necessary to protect all the resident's and staff.

During an interview, a nurse stated she met with the resident to complete an assessment for potential placement at the facility she worked for. The nurse stated she received the resident's medication list from AP-1, and AP-1 let her know special arrangements were made for the resident to see FM-1 as she was not allowed on campus. The nurse stated the resident's spouse let her know he used a camera in the resident's room due to staff not having the resident up and ready when he wanted her ready. The nurse stated FM-1 wanted to be apart of the assessment, but the spouse hung his phone up on FM-1 to cut her out. The nurse stated it was unclear to her who the resident's guardian was. The nurse stated the resident's spouse told her about the restraint on FM-1. The nurse stated her managers made the final decision on new patient admissions, and they decided not to take the resident due to family drama that would not make the resident a fit at their facility. The nurse stated if the family drama concern was not there, the nurse's facility would have accepted the resident for placement.

During an interview, the legal guardian stated he became the resident's guardian when the resident's spouse petitioned for one, two months after FM-1 was trespassed from the facility. The legal guardian stated he makes all final decisions regarding the resident. The legal guardian stated there had been a lot of lying and slandering towards him and the staff at the facility by FM-1. The legal guardian stated FM-1 violated the trespass order several times. The legal guardian stated FM-1 violated the facility's policies several times despite many warnings and

many chances to rectify. The legal guardian stated the trespass order could have been avoided. The legal guardian stated he instructed the facility to remove the second camera placed in the resident's room by FM-1 due to FM-1 not following the proper procedure for placing the camera. The legal guardian stated there were a few reasons the trespass order was placed on FM-1, including staff noticing FM-1 force feeding the resident, FM-1 continually placing a cushion in the resident's chair that was linked to causing falls from the chair despite multiple warnings to not use the cushion, and FM-1 being verbally and physically aggressive towards staff which upset other residents as well. The legal guardian stated FM-1 was causing a lot of commotion every time she came to the facility. The legal guardian stated he felt it was appropriate for the facility to trespass FM-1. The legal guardian stated the resident appeared happy and cheerful every time he saw her. The legal guardian stated he felt the resident's needs were met at the facility, and he has never had any concerns about the care the resident received at the facility. The legal guardian stated FM-1 had been the center of all conflict with her family and the facility.

During an interview, an unlicensed personnel (ULP)-1 stated FM-1 would try to jump in and use the facility's mechanical equipment, and insisted ULP-1 did not need to call another staff member to perform a two person transfer with the resident, because she could do it. ULP-1 stated FM-1 got mad at ULP-1 when she called for another staff member to help.

During an interview, ULP-2 stated he witnessed the resident become upset and say "no" when he would bring her downstairs to get on the bus for a family visit. ULP-2 stated there was an incident when he entered the resident's room and FM-1 had attempted to use the mechanical lift with the resident, and FM-1 did not have the lift sling properly attached. ULP-2 stated since FM-1 had not been coming to the facility, he noted the resident to be more attentive in group activities, more engaged with less behaviors, and calmer.

During an interview, FM-1 stated there was two cameras placed in the resident's room. One for her father to use, and the other for her to use. FM-1 stated the facility removed the camera without asking or telling the resident's family, and the legal guardian knew nothing about it. FM-1 stated AP-1 requested a care conference, but she did not know why she was selected to have one as no other residents were having one. FM-1 stated AP-1 approached her about interfering with the elevator code and a wheelchair cushion. FM-1 stated she told AP-1 she did not want to talk about it and walked away. FM-1 stated AP-1 then emailed her and trespassed her from the facility. FM-1 stated she never harassed anyone, and the facility called the police on her because they said she was giving medications to other residents, and they do not have proof of that. FM-1 stated the facility was abusing the resident by keeping her away from FM-1. FM-1 stated she no longer had guardianship of the resident because the resident's spouse feared the idea of moving the resident, and she wanted to move the resident to another facility. FM-1 denied physically lunging at AP-2, and stated she was afraid of AP-1 and AP-2.

During an interview, FM-2 stated she had concerns about the care the resident received. FM-2 stated after the nurse spoke to AP-1, they no longer would place the resident at their facility.

FM-2 stated AP-1 told the nurse about the resident's behaviors and manipulated and harassed the resident's family. FM-2 stated AP-1 overstepped the boundaries of her role. FM-2 stated there was a long list of micro events that led to the trespass order of FM-1. FM-2 stated the facility gave the family a document that listed 27 reasons for the trespass order, and only eight of them included FM-1. FM-2 stated the facility only attempted to meet with the family one time, and FM-1 was too stunned to do something about it. FM-2 stated the legal guardian does not want the resident to move to another facility, and the legal guardian was on the side of the facility. FM-2 stated the resident's rights were being violated, and now they must arrange transportation for the resident to visit FM-1 at her home. FM-2 stated the resident was sad when she returned to the facility from a family visit.

During an interview, FM-3 stated he initially did not want the resident to move to another facility, but he would now like her to move due to conflict with facility management and the restrictions they placed on FM-1. FM-3 stated the legal guardian was not allowing for any kind of move and he planned on firing the legal guardian. FM-3 stated the care the resident received was good from the people who work directly with her, so if it was not for poor management, he would have the resident stay. FM-3 stated he felt they will be stuck at the facility and find no other facility to accept the resident due to the things AP-1 has stated. FM-3 stated he had to obtain a lawyer due to FM-1 doing things behind his back, such as applying for emergency guardianship of the resident. FM-3 stated the resident was doing well, smiling, alert, laughs and was in good spirits. FM-3 stated the resident was doing so well that she may be ending her hospice services.

During an interview, a licensed social worker stated she has never had concerns about the care the resident received at the facility. The social worker stated the resident always had what she needed and was engaged. The social worker stated the facility reported to her their staff have been yelled at and received other verbal aggression from FM-1. The social worker stated the legal guardian made good decisions to maintain appropriate care of the resident. The social worker stated there have been chances for restrictions to open for FM-1, but family defied facility restrictions time and time again. The social worker stated she was in support of the facility to do what they need to do to keep staff and residents safe. The social worker stated she had not seen any decline in the resident since FM-1 was trespassed from the facility. The social worker stated the resident's dementia allowed for her to adapt to circumstances, and she did not realize FM-1's absence.

During an interview, the resident stated "yes" when asked if she can see her family. The resident stated "no" when asked if she felt sad. The resident stated "yes" when asked if she liked living at the facility. The resident stated "I don't know" when asked if she wanted to move to a different facility. The resident was noted to also have non sensical speech at times and point at items that did not appear to the investigator.

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; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility provided records for another facility to review for placement.

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: 30751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/21/2025
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NAME OF PROVIDER OR SUPPLIER THE COMMONS ON MARICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 MARICE DRIVE EAGAN, MN 55121
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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 April 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL307512444C/#HL307511543M. No correction orders are issued.</p>	0 000		

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