Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308091260M
Compliance #: HL308091820C

Date Concluded: May 12, 2025

Name, Address, and County of Licensee Investigated:
PSC of Isanti
706 6th Avenue NE
Isanti, MN 55040
Isanti County

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

Evaluator's Name: Katherine Barnhardt 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 facility emotionally abused the resident when unlicensed facility staff shaved the resident's hair in retaliation for the resident requesting staff prepare him a sandwich. Staff physically restrained the resident during the haircut.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Facility unlicensed staff did cut the resident's hair; however, the resident gave the staff permission to cut his hair, and the resident verbalized to the investigator he liked his haircut. No harm resulted from the resident haircut. There was no evidence the resident was restrained during the haircut. Additionally, facility staff provided the resident with his preferred snack of peanut butter and jelly sandwiches anytime requested throughout each day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's advocate and a

family member. The investigation included review of the resident record(s), pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed facility staff provide direct care to the resident and the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a stroke, major depressive disorder and cognitive communication deficit. The resident's service plan included assistance with personal cares, medication administration, safety checks and bathing. The resident was able to make his needs known to staff with a history of being demanding and refusing cares. The resident utilized a wheelchair for mobility and required reminders and staff assistance with preparing foods.

The resident's record indicated the resident had worn his hair shoulder length most of his adult life. The resident's record indicated the resident was resistive to bathing and at times would be verbally or physically aggressive with staff when assistance with care tasks was offered. The resident's record indicated unlicensed staff offered and provided snacks for the resident throughout the day.

Progress notes indicated a friend of the resident visited the facility and was upset that staff had cut the resident's hair. The resident's friend said she knew someone that cut hair and stated she would have scheduled a haircut at the facility for the resident. Unlicensed staff reported during the resident's bath as they were trimming the resident's hair the resident told unlicensed staff to cut it all off. The resident was not upset during or after the haircut.

During an interview, unlicensed staff stated some families and residents ask staff to trim their hair. Unlicensed staff stated the resident had shoulder length hair and often refused bathing but one day while she was at work she trimmed the resident's hair and the next day when she returned to work the resident's hair was short. Unlicensed staff stated the resident rubbed his head showing off the new haircut. Unlicensed staff stated she was told while the resident was being assisted with a bath other unlicensed staff asked the resident if he would like a haircut and the resident stated yes and told the unlicensed staff to take it all off. Unlicensed staff stated the resident had not complained, acted depressed or expressed any unhappiness with the haircut. Unlicensed staff stated the haircut was offered because the resident's hair was "getting icky" because the resident refused bathing and would spray stuff in his hair. Unlicensed staff stated the resident was excited to show off his new haircut.

During an interview, another unlicensed staff stated it was not uncommon for residents or families to request unlicensed staff trim or cut residents hair or beards. Unlicensed staff stated a coworker had trimmed the resident's hair a couple days earlier and when unlicensed staff gave the resident a bath unlicensed staff asked if the resident wanted his hair trimmed again and the resident said yes. The resident was taken to the facility beauty salon and unlicensed staff trimmed off a couple inches at a time and asked the resident if he liked it in between and he said yes and wanted a couple more inches off and the resident "really liked it" and asked for

more to be cut off until it was cut short. Unlicensed staff stated it seemed to boost his self-esteem and he seemed excited. Unlicensed staff stated he was very proud of his new haircut, however, a few hours later a friend arrived for a visit and was very vocal and upset with staff. Unlicensed staff stated the resident told the friend he liked the haircut until the resident realized the friend was upset about the cut. Unlicensed staff stated the resident requested between fifteen and twenty peanut butter and jelly sandwiches during the day and the unlicensed staff had not retaliated against the resident by cutting his hair when he asked for a sandwich.

During an interview, licensed staff stated it was not uncommon for residents or family members to request staff trim residents' hair. Licensed staff stated unlicensed staff should have checked with a licensed staff prior to following through on the resident's instructions to cut his hair, however, the resident had reported to licensed staff he liked the haircut. Licensed staff stated a friend of the resident was unhappy with the haircut because the friend had always known the resident to have longer hair. Licensed staff stated the resident had told staff to "take it all off or something like that". Licensed staff stated the friend did not feel the resident had the clarity to understand what that meant and was upset with facility staff. Licensed staff stated the facility was not notified that a barber appointment had been setup by the resident's friend. Licensed staff stated the facility no longer allowed unlicensed staff to trim or cut residents' hair, even when requested.

During interview, the resident stated about a month ago while bathing he got a haircut from unlicensed staff, and he liked the haircut. The resident stated staff asked if they could cut his hair and he told them yes. The resident stated he had never had a barber come to the facility to cut his hair and he felt safe at the facility. The resident stated he had no concerns with the haircut.

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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility no longer allows licensed or unlicensed staff to cut or trim resident’s hair.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

(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 On April 24, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL308091820C/#HL308091260M. No correction orders are issued.	0 000		