Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318566542M
Compliance #: HL318569769C

Date Concluded: February 5th, 2025

Name, Address, and County of Licensee Investigated:
Minnetonka Care Residence
421 Spring Valley Drive
Bloomington, MN 55420
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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), a facility staff member, abused the resident when the AP was observed on video taunting the resident about taking her medications and "hip checked" (physical maneuver where someone uses their hip to bump into another person) the resident knocking her to the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility and the AP were responsible for the maltreatment. The video showed the AP taunting the resident saying, "I bet you won't hit me, I bet you won't hit me." The AP used her buttocks and pushed the resident to the ground and walked away while the resident was on the floor. Facility policies and procedures were not followed by facility management after suspected abuse was reported and no immediate action was taken to protect resident safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease, degenerative disc disease, and chronic low back pain. The resident's service plan included assistance with medication administration and behavior management. The resident's assessment indicated the resident was at risk of being abuse and needed redirection for agitation.

Video footage showed the AP attempting to administer medications to the resident. The AP stated, "I don't know who you think you is." AP's voice got louder, and she stated, "are you gonna take your meds yes, or no?" "Yes, or no?" "Do you want to take your medicine?" The resident made a face at the AP. The AP stated "ok" and put the medications in the cabinet. The AP then walked towards the resident. The resident stretched out her right arm with a clenched fist in front of the AP. The video was not clear if the resident's arm made contact with the AP's body. The AP stopped and turned around and left the kitchen area. The AP was then seen entering the kitchen stating, "I bet you won't hit me, I bet you won't hit me, I bet you won't hit me, I bet you won't hit me." While the AP was saying that, the resident walked up to the medication cabinet and attempted to open it and the AP attempted to intervene. The resident and AP were both trying to get the pad lock from the cabinet when the altercation moved out of the sight of the camera. The AP was then seen walking back into the kitchen and appeared to be putting the lock back on the medication cabinet. The resident came up behind the AP, reached up to the cabinet and attempted to grab the lock. While the resident was behind the AP, the AP pushed her buttocks backwards into the resident. The resident fell backwards onto the floor. The AP started to leave the room and the resident stated she was going to call 911. The AP turned back and looked at the resident sitting on the floor and left the room. The resident got up on her own, looked at her left elbow and grabbed the phone.

The facility incident report completed by the AP and facility nurse indicated the resident was reminded she could not assault facility staff. The incident report indicated the facility was looking for alternate placement for the resident because of behavioral issues.

During an interview, the AP stated, the resident refused her medications. The AP stated she thought she locked the cabinet but when she turned her back, the resident had taken the lock. The AP stated she got the lock back from the resident and the next thing she knew the resident was on her back. The AP stated she put her arms down and the resident fell off her back. The AP stated she never touched the resident, and acknowledged that she did not help the resident when she was on the ground.

During an interview, the facility nurse stated the AP ended up “hitting” the resident “a little bit” and the resident hit her bottom. The AP should not have responded to the resident the way she did. The facility nurse stated she did not feel bumping the resident to the ground was abuse.

During an interview, facility management stated the AP called him about the incident and he watched the video right away. Facility management stated he saw on the video that the resident did not want to take her medications. The AP asked the resident if she wanted to take her medications and the resident stated no. Facility management stated the resident started to escalate in her behaviors. The AP went to wash her hands and the resident punched the AP in the chest. The AP and resident were trying to get the lock for the medication cabinet. The AP got the lock and when she was trying to lock the cabinet, the resident was behind the AP. The resident stepped backwards and fell. Facility management stated the AP checked on the resident. The resident got up and walked back to her room. Facility management stated to a certain degree the incident was abuse but it was also self-defense. The AP was given a corrective action and completed education after the incident. Facility management stated he did not report the incident because he did not feel it was “fully” abuse.

During an interview, the case worker stated he visited the resident the day after the incident and the resident would not get out of bed and was trembling.

During an interview, the resident stated the day of the incident the AP was “taunting” her about her medications. The resident stated she was injured several times by the AP and made several reports but no follow up was ever done.

The AP’s employee record lacked evidence education or corrective action was taken after the incident.

In conclusion, the Minnesota Department of Health determined 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) 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: No. Resident requested family not be interviewed.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department
Minnesota Board of Executives for Long Term Services and Support
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31856	A. BUILDING: _____ B. WING _____	C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNETONKA CARE RESIDENCE	421 SPRING VALLEY DRIVE BLOOMINGTON, MN 55420

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL318569769C/#HL318566542M #HL318566781C On December 16, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction order orders are issued for #HL318569769C/#HL318566542M, tag identification 0620, 1290, 2320 and 2360. The following correction order orders are issued for #HL318566781C, tag identification 1790.	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	

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0 620	Continued From page 1	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 2 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment / abuse for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 620		

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0 620	Continued From page 3 The findings include: R1 admitted to the facility on May 26, 2020. R1's diagnoses included Parkinson's disease, chronic low back pain, and scoliosis or thoracolumbar spine. The facility's video footage dated October 10, 2024, revealed ULP-A was in the kitchen, she walked to the medication cabinet and left the keys in the lock and walked away. R1 entered the room and ULP-A approached the medication cabinet, opened the medication cabinet. ULP-A was heard stating, "I don't know who you think you is." ULP-A got medications ready and set them on the counter. ULP-A stated in a louder voice, "are you gonna take your meds yes, or no?" Then ULP-A stated "Yes, or no?" "Do you want to take your medicine?" R1 made a face and ULP-A stated ok and put the medications in the cabinet and locked it. ULP-A walked towards R1, R1 put her arm up outstretched to her right side with a closed fist. ULP-A stopped when she reached R1's arm. R1's arm was at ULP-A's chest level. ULP-A turned around and walked out through the other doorway behind her. ULP-A then came through the other doorway and said, "I bet you won't hit me, I bet you won't hit me, I bet you won't hit me, I bet you won't hit me." R1 walked up to the medication cabinet and attempted to open it. R1 attempted to grab the lock. R1 and ULP-A were both trying to get the lock and the altercation moved out of the sight of the camera. ULP-A was seen walking back into the kitchen and put the lock on the medication cabinet. R1 came up behind ULP-A and attempted to grab the lock on the cabinet. ULP-A used her buttocks to hip check the R1 and R1 fell to the floor. ULP-A walked out of the room and as she did she looked back R1. R1 stated she was	0 620		

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0 620	Continued From page 4 going to call 911, got up on her own and looked at her elbow and grabbed the phone. During an interview on December 19, 2024, at 9:30 a.m., LALD-C confirmed the facility failed to file a MAARC report within 24-hours of the incident and stated they didn't feel the incident was "fully" abuse. During an interview on December 19, 2024, at 11:20 a.m., DON-E stated the incident wasn't reported because they did not feel it was maltreatment. The licensee's Vulnerable Adult Maltreatment Policy undated, indicated any staff who suspects maltreatment of a vulnerable adult needs to report the incident to their supervisor immediately. Immediately means as soon as possible but no longer than 24 hours. The policy lacked the definition of maltreatment or abuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290		

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01290	Continued From page 5 section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure background study clearance letter for one of one employee was completed and affiliated with the licensee's facility identification number (HFID). In addition, the background study provided to the investigator with an incorrect HFID indicated unlicensed personnel (ULP)-A was disqualified from any position allowing direct contact with, or access to, people receiving services from the licensee. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: The facility hired ULP-A on May 17, 2023, to provide direct care services to the licensee's residents. On December 16, 2024, at 10:00 a.m., the surveyor observed ULP-A was the only staff present at the licensee and provided supervision	01290		

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01290	Continued From page 6 of R2 and made a meal for R2. ULP-A's record lacked documentation of a background study affiliated with the licensee. ULP-A's record had documentation of a background study completed September 22, 2023, for a different licensee. The background study indicated ULP-A was disqualified due to misdemeanor assault and felony drugs. The background study indicated a reconsideration was requested and approved, but ULP-A was only allowed to provide services for Parkinson's Specialty Care. The background study lacked evidence the reconsideration was approved for the licensee. On December 17, 2024, a review of the Department of Human Services (DHS) Background Net Study website identified the licensee had no background checks affiliated with the HFID of the licensee. During an interview on December 19, 2024, at 9:30 a.m., licensed assisted living director (LALD)-C stated the licensee completed background checks under Parkinson's Specialty Care which was identified as an umbrella license for the agency. LALD-C stated the background studies were not done for the licensee. The licensee's undated Background Checks Policy, noted employees may not have independent direct contact with any residents until an acceptable result of the background study have been received. The facility will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided.	01290		

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01290	Continued From page 7 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790		

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01790	Continued From page 8 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01790		

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01790	Continued From page 9 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On December 31, 2024, licensed practical nurse (LPN)-F provided medication management services to R2 when R2 was leaving the facility for a leave of absence. R2 ' s December medication administration record (MAR) indicated the following: Lamictal 200 milligram (mg) give one tablet (tab) by mouth three times a day scheduled at 6:00 p.m. Aricept 5 mg small round white tablet scheduled at 8:00 p.m. Keppra 1000 mg give one tab by mouth twice a day scheduled at 8:00 p.m. Rosuvastatin 40 mg administer one tablet at 8:00 p.m. Clobazam 10 mg in narcotic box, give one tab orally two times a day scheduled at 9:00 p.m. Review of a picture of the pill packets indicated one pill associated with the white envelope labeled 6:00. Four pills associated with the white envelope labeled "[R2] MEDS 8:00." One pill associated with the envelope labeled 9:00. On December 31, 2024, at 1:40 p.m., LPN-F stated R2 received medications preset up from the pharmacy. LPN-F stated she did not set up R2 ' s medications and was not aware of a concern.	01790		

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	31856	A. BUILDING: _____ B. WING _____	C 12/16/2024

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01790	Continued From page 10 On January 9, 2025, at 7:52 a.m., director of nursing (DON)-E indicated the expectation for when residents go out on a leave of absence was to print out the MAR, confirm with the family member that they have all the medication needed and document in Rtask that the resident is on a leave of absence. R2 ' s medical record lacked evidence the resident was provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances. The medical record lacked evidence the medications were placed in containers appropriate to the provider's medication system and were not labeled with the resident's name and date that the medications are scheduled. The medical record lacked evidence how the registered nurse should be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative. The medical record lacked evidence a review by the registered nurse was completed of this task to verify that this task was completed accurately by the facility staff. The medical record lacked evidence how the medications must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. The licensee's Delegation of Medication to be given to Residents by Unlicensed Staff for Residents Time Away from Home policy, dated July 29, 2021, the licensee will provide the	01790		

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01790	Continued From page 11 necessary medications, education, instructions and support to meet the resident's medication needs when they are away from home if the licensee provides assistance with administration of medication or storage of medications. TIME PERIOD FOR CORRECTION: Seven (7) days.	01790		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) when a staff member verbally instigated R1 and then pushed R1 with her buttocks knocking R1 to the ground. In addition, the staff member was disqualified to work for the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	02320		

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02320	Continued From page 12 has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the facility on May 26, 2020. R1's diagnoses included Parkinson's disease, chronic low back pain, scoliosis, or thoracolumbar spine. R1's plan of care dated March 16, 2024, indicated R1 required assistance with medication administration and behavior management. R1's plan of care indicated staff were to document instances of behavior. R1's plan of care lacked evidence of interventions for behaviors. R1's assessment dated September 27, 2024, indicated R1 was at risk for physical and verbal abuse. Staff were to monitor for signs of agitation, remove the resident or other residents from the area, and report any concerns. Unlicensed personnel (ULP)-A was hired May 17, 2023, to provide direct care services to the licensee's residents. ULP-A's employee record indicated on September 22, 2023; a sister facility of the licensee had completed a background study. The background study indicated ULP-A was disqualified from any position allowing direct contact with people receiving services by the licensee. The background study indicated ULP-A was disqualified due to misdemeanor assault and felony drugs. The background study indicated a reconsideration was requested and approved, but ULP-A was only allowed to provide services for Parkinson's Specialty Care. The background study lacked evidence the reconsideration was approved for the licensee. The employee record	02320		

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02320	Continued From page 13 lacked evidence the licensee completed a background study on ULP-A. ULP-A's employee record indicated on July 24, 2024, ULP-A received a written warning and placed on a 2-week suspension for repeated complaints or concerns from residents, family, and administration. An incident report dated October 10, 2024, indicated (ULP)-A was attempting to administer R1's medications and R1 would not take them. ULP-A put the medication back into the cabinet and attempted to lock the cabinet. R1 got the lock off the cabinet and ULP-A got the lock back from R1. The incident report indicated R1 jumped on ULP-A's back and R1 fell onto the floor. Follow up on the incident report completed by director of nursing (DON)-E indicated the video footage was reviewed and R1 was reminded she can't assault caregivers. The follow up indicated case worker (CW)-D was looking for alternate placement for R1 because of behavioral issues. The facility's video footage dated October 10, 2024, revealed ULP-A was in the kitchen, she walked to the medication cabinet and left the keys in the lock and walked away. R1 entered the room and ULP-A approached the medication cabinet, opened the medication cabinet. ULP-A was heard stating, "I don't know who you think you is." ULP-A got medications ready and set them on the counter. ULP-A stated in a louder voice, "are you gonna take your meds yes, or no?" Then ULP-A stated "Yes, or no?" "Do you want to take your medicine?" R1 made a face and ULP-A stated ok and put the medications in the cabinet and locked it. ULP-A walked towards R1, R1 put her arm up outstretched to her right side with a closed fist. ULP-A stopped when she	02320		

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02320	Continued From page 14 reached R1's arm. R1's arm was at ULP-A's chest level. ULP-A turned around and walked out through the other doorway behind her. ULP-A then came through the other doorway and said, "I bet you won't hit me, I bet you won't hit me, I bet you won't hit me, I bet you won't hit me." R1 walked up to the medication cabinet and attempted to open it. R1 attempted to grab the lock. R1 and ULP-A were both trying to get the lock and the altercation moved out of the sight of the camera. ULP-A was seen walking back into the kitchen and put the lock on the medication cabinet. R1 came up behind ULP-A and attempted to grab the lock on the cabinet. ULP-A used her buttocks to hip check the R1 and R1 fell to the floor. ULP-A walked out of the room and as she did she looked back R1. R1 stated she was going to call 911, got up on her own and looked at her elbow and grabbed the phone. R1's medical record lacked evidence of R1 had any behaviors the day of the incident. The licensee's staffing schedule the day of the incident indicated ULP-A worked at the facility from 7:00 a.m. to 11:00 p.m. During an interview on December 17, 2024, at 10:00 a.m., ULP-A stated R1 was refusing her medications, and the medications were placed back in the cabinet. ULP-A stated she thought she locked the cabinet but when she turned her back, R1 had taken the lock. ULP-A stated she got the lock back from R1 and the next thing she knew R1 was on her back. ULP-A stated she put her arms down and R1 fell off her back. ULP-A stated she never touched R1. ULP-A stated she did not help R1 when she was on the ground. During an interview on December 19, 2024, at 9:30 a.m., licensed assisted living director	02320		

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02320	Continued From page 15 (LALD)-C stated ULP-A called him about the incident. LALD-C stated R1 did not want to take her medications. ULP-A asked R1 if she wanted to take her medications and R1 stated no. LALD-C stated R1 started to escalate in her behaviors. ULP-A went to wash her hands and R1 punched ULP-A in the chest. ULP-A and R1 were trying to get the lock for the medication cabinet. ULP-A got the lock and when she was trying to lock the cabinet, R1 was behind ULP-A. R1 stepped backwards and fell. ULP-A checked on R1, R1 got up and walked back to her room. LALD-C stated to a certain degree the incident was abuse but it was also self-defense. LALD-C stated ULP-A was given a corrective action and completed education after the incident. LALD-C did not report the incident because he did not feel it was "fully" abuse. During an interview on December 19, 2024, at 11:20 a.m., DON-E stated if a resident had behaviors staff are educated to walk away and give the resident time to calm down. If that was not effective staff are to call the DON or LALD for assistance. DON-E stated ULP-A should not have talked to R1 the way she did, it wasn't therapeutic communication. DON-E stated when R1 fell to the floor it was because ULP-A "bumped her a little bit." DON-E stated although ULP-A should not have responded to the incident the way she did, she did not feel it was maltreatment. During an interview on December 19, 2024, at 10:00 a.m., case worker (CW)-D stated he visited R1 the day after the incident and R1 would not get out of bed and was trembling. During an interview on December 27, 2024, at 9:49 a.m. R1 stated the day of the incident ULP-A was "taunting" her about her medications. R1	02320		

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02320	Continued From page 16 stated she got injured several times by ULP-A and made several reports but no follow up was ever done. ULP-A's employee record lacked evidence any corrective action or education was conducted by the licensee after the incident. The licensee's Vulnerable Adult Maltreatment Policy undated, indicated any staff who suspects maltreatment of a vulnerable adult needs to report the incident to their supervisor immediately. Immediately means as soon as possible but no longer than 24 hours. The policy lacked the definition of maltreatment or abuse. The licensee's undated Professional Behavior Required by Employees policy indicated employees were hired with the understanding that they will be caring and compassionate towards each of the residents. The employee's goal was to relate in a positive way to each resident. Employees are never to show anger, disgust, or impatience to a resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by:	02360		

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02360	Continued From page 17 The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details	02360		