Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL33084002M **Date Concluded:** October 13, 2021

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care
8500 Regent Avenue North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Laura duCharme, RN
Rapid Response Evaluator

Finding: Substantiated, individual responsibility

Nature of Visit:
An investigator from 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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) verbally and physically abused the client when he made derogatory and threatening statements to the client. In addition, the AP grabbed and pushed him to the ground then held the client by his neck area to the ground resulting in scratches on the client's neck and shoulder.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP threatened the client with physical abuse and physically assaulted the client. As a result, the client experienced increased agitation and scratches to both sides of his neck.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and a family member. The investigator also reviewed medical records, the AP's employee file, law enforcement reports, facility policies and procedures, and video and audio footage of the incident provided by the facility administration.

The client lived at the facility for a few months prior to the incident due to Alzheimer's Disease. The client's care plan indicated the client required assistance with bathing, grooming, dressing, and toileting. In addition, the care plan indicated the client had moderate disorientation, difficulty retaining information, and not understanding surroundings and current situations. The care plan directed staff to allow the client to acclimate to the situation using a calm soft voice, approach him in a calm quiet manner, or call his family.

On the day prior to the physical abuse, although out of camera view, the audio captured AP swearing at and threatening physical abuse to the client.

On the day of the incident, the client laid on the couch in the common area with his eyes closed. The AP approached him with crushed medications in chocolate pudding and told him to eat the chocolate pudding. The client refused. A short time later the AP reapproached the client with the medication, the client appeared confused and refused again. The client got off the couch and walked away from the AP. The AP yelled to the client, "I am just trying to help your retarded ass" and a physical altercation began. The video footage showed the AP grab the client, swing him around to the ground, and sat on top of the client while yelling at him. The client got off the floor and walked away. The AP dialed his cell phone and called registered nurse (RN)-D to report he had been attacked by the client. RN-D went to the facility to review the camera footage. RN-D sent the AP home pending investigation.

Multiple administration staff interviews indicated they viewed the camera footage of the two incidents of abuse. Their interpretation of the videos was consistent. They did not review any additional camera footage beyond the two incidents. The first audio recording revealed the AP threatening the client, "I am not afraid of you. I am not the one; if you hit me, I will hit your ass back. You're not going to hurt me. I will lay your ass out". The second camera footage revealed the client laying on the couch with his eyes closed when the AP stood over him trying to give him meds. The client did not appear to understand what was happening and did not want to take the medications. The client walked away from the AP. The AP yelled at the client, "You're looking like you're crazy. I'm just trying to help your retarded ass," then threw the client to the floor and put his hands near the client's neck and shoulder area. The client's shirt was ripped, and he had scratches on both sides of his neck.

When interviewed, the client's family member stated she was notified of the incident. Described the client was a veteran with significant memory loss who has been aggressive most of his life but very protective of women. She stated the client was not able to communicate adequately to make his needs known and facility staff were responsible for all his cares.

When interviewed, RN-D described the client as a "younger man" with early onset dementia who had served in the military. She stated she trained staff to approach the client calmly to avoid triggering aggressive behavior. RN-D further stated the AP did not approach the client as he had been trained. RN-D stated she received a phone call from the AP the night of the incident and had told her the client had attacked him and ripped his shirt. She immediately

went to the facility to find the client “nerved up” with some scratches on both sides of his neck. She had the AP leave the facility immediately, assessed the client’s injuries, and watched the video footage of the incident. She described the video footage of the incident as the AP abruptly woke the resident to take medication; the resident did not appear to understand what was happening, put his hands up in the air and stood up to walk away from the AP. The AP cut the client off in his path, the client pushed the AP and “slammed him to the floor” while screaming at him. After watching the video footage, she notified the housing director and terminated the AP’s employment.

When interviewed, the AP admitted to using unprofessional language and his force may have been excessive but felt he needed to restrain the VA.

Review of the AP’s employee file indicated he had been employed for approximately three months prior to the incident and had completed all required training and competencies. There was no evidence of previous incidents or related disciplinary action.

In conclusion, 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;
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, the client was nonverbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The nurse immediately removed the AP and conducted an investigation. The AP is no longer employed at the facility. The housing director re-trained all staff on anger and aggression 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33084	A. BUILDING: _____ B. WING _____	C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE	580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127

(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 The Minnesota Department of Health investigated an allegation of maltreatment, complaint HL33084002M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for HL33084002M, tag identification 325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by. " Following the investigators ' 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/RULES.	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On October 13, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction required for tag 325. Please see public maltreatment report (report sent separately) for details.	