

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL33262001M
Compliance #: HL33262002C

Date Concluded: November 10, 2021

Name, Address, and County of Licensee

Investigated:

Cherrywood Pointe of Roseville
2680 Lexington Avenue North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit: 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), facility staff, verbally abused a resident when the AP screamed at the resident with degrading statements.

Investigative Findings and Conclusion:

Abuse was substantiated. The AP was observed on video screaming at the resident, berating him for having a bowel movement, and telling the resident that he had to clean himself up. The AP roughly shoved the resident in his wheelchair into the kitchen, continued to yell at the resident for several minutes until the resident cried and begged for God to help him.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted family. The investigator observed staff/resident interactions and cares, reviewed resident records, facility documents, facility policies and procedures related to staff orientation/training, employee code of conduct, and maltreatment of vulnerable adults.

The resident lived in the assisted living facility for about one year due to diagnoses that included heart disease, lactose intolerance, hearing loss, and atrial fibrillation. The resident received services from the assisted living provider that included registered nurse assessments, COVID-19 screening, shower assistance, nail care, nurse monitoring visits, housekeeping, laundry, medication administration, escorts to meals, safety checks, and toileting (which included assisting the resident to the bathroom and changing his incontinence briefs).

One evening a family member reviewed video of the resident's apartment and saw/heard the AP yelling at the resident about having to change the resident's incontinence brief. The family member saw and heard the AP scream at the resident and told him to clean himself up after having a bowel movement in his incontinence brief. The AP berated the resident, telling him he smelled, and wishing he would move out of the facility.

The family member contacted the director of health services, who began an investigation along with the executive director. The director of health services placed the AP on leave and reviewed the video.

On the video, the AP, over the course of about 15 minutes of interaction with the resident, made disparaging comments about how he smelled, told the resident he smelled like "shit" threatened to not clean up the resident, and told the resident that the AP wished he would move out.

The AP then forcefully pushed the resident in his wheelchair into the kitchen area and the resident began to cry. The resident cried for God to help him, and for God to let him die.

During an interview, a family member said she placed the video camera in the apartment due to concerns about staff failure to provide services. The family member said all staff knew the camera was in the apartment. The family member said she reviewed the video frequently and on the night of the incident, she called the director of health services immediately.

During an interview, the director of health services said that when she heard about the incident, she took the AP off the schedule and began an investigation. The director of health services said she took a statement from the AP, reviewed the video, and interviewed a family member. The director of health services said that she and the interim executive director communicated with the AP and terminated her employment.

During an interview the AP said it was a one-time incident. The AP said that on the night of the incident she could tell that the resident had a bowel movement in his incontinent briefs because he smelled. The AP said that she lost her temper and yelled at the resident. The AP said that she used the cold wipes with the resident and should have used a warm washcloth but was angry. The AP said that she did not push or shove the resident but told him that he had to help. The AP also verified that she had an incident at another facility where she lost her temper and

yelled at a resident with Parkinson's disease because he wobbled around. The AP denied a third reported incident because that resident "made up stories and complained about everyone."

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;
 - (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, unable to interview due to cognitive impairment.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Ramsey County Attorney
Roseville City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/20/2021
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NAME OF PROVIDER OR SUPPLIER CHERRYWOOD POINTE AT LEXINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2680 LEXINGTON AVENUE NORTH ROSEVILLE, MN 55113
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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
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0 000	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G, the Minnesota Department of Health issued a correction order pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On October 20, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL33262002C/#HL33262001M. At the time of the survey, there were #128 residents receiving services under the assisted living license.</p> <p>The following correction order is issued for #HL33262002C/#HL33262001M tag identification 2360.</p>	0 000	<p>The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>Per Minnesota Statute §144G.30, Subd. 5 (c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."</p>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced</p>	02360		

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

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02360	<p>Continued From page 1</p> <p>by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused.</p> <p>Findings include:</p> <p>On October 20, 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.</p>	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	