*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL339549142M
**Compliance #:** HL339547484C

**Date Concluded:** April 21, 2025

**Name, Address, and County of Licensee Investigated:**
Suite Living Senior Care of LI
197 County Road B2 West
Roseville, MN, 55113
Ramsey County

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

**Evaluator's Name:** Angela Vatalaro, RN
Special Investigator

**Finding:** Inconclusive

**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 staff member, abused the resident when the AP poured water on the resident.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting reports of the incident. A witness stated the AP poured water on the resident when the AP became frustrated however, the AP denied pouring water on the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigation included review of the resident records, facility internal investigation, incident reports, a personnel file, and related facility policy and procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease and Alzheimer's dementia. The resident's service plan included assistance with dressing, bathing, toileting, and assistance with transfers using a mechanical lift. The resident's behavior plans included assistance with managing the resident's agitation, physical and verbal aggression, hallucinations, delusions, reluctance to accept care, and adjustment to residing in an assisted living. The resident's assessment indicated the resident had unsafe behaviors including placing herself on the floor and unsafe self-transfers. The resident used a wheelchair for mobility and was not oriented to person, place, and time.

The facility's internal investigation indicated one day it was reported the resident was hanging halfway off her bed. The AP requested another unlicensed personnel to assist her. The unlicensed personnel stated the AP told the resident she was "tired" of her and proceeded to pour cold water on the resident and the AP walked out of the room.

During an interview, an unlicensed personnel stated the AP asked for assistance with the resident. The resident was halfway out of her wheelchair and her upper body was halfway in bed. The unlicensed personnel stated the AP said she was "tired" of the resident jumping out of her wheelchair. The unlicensed personnel stated the AP took a cup of water and poured the water on the resident's head and left the room. The unlicensed personnel stated there was enough water in the cup that the resident's hair got wet. The unlicensed personnel dried the resident's hair and finished assisting the resident into bed.

During an interview, the AP denied pouring water on the resident. The AP said it may have appeared that she had, however she had a glass of water in her hand for the resident to drink. The AP stated she was attempting to assist the resident into bed when the glass of water slipped out of her hand, landed on the resident and the resident's bed.

During an interview, a nurse stated the resident had dementia and had several behaviors. At times, the resident threw plates, threw food, threw drinking cups, and spilled drinking cups of fluid throughout the building. The facility conducted an internal investigation. The AP and another unlicensed personnel were in the resident's room assisting the resident. An unlicensed personnel said he witnessed the AP pour water on top of the resident's head, which was enough water to cause the resident's hair to become wet. The AP denied pouring water on the resident.

During an interview, leadership stated the AP denied pouring water on the resident.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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**: Yes.

**Action taken by facility:**
The facility conducted an internal investigation and reeducated all staff on reporting requirements, reporting immediately, and trained on the facility's reporting policy. The AP is no longer employed by the facility.

**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 |
|---|---|---|---|
| | 33954 | A. BUILDING: _____ B. WING _____ | C 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUITE LIVING OF ROSEVILLE | 197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL339547484C/#HL339549142M<br><br>#HL339549061C/#HL339549682M<br><br>On March 11, 2025, 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 20 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>For #HL339547484C/#HL339549142M. No correction orders are issued.<br><br>The following correction order is issued for #HL339549061C/#HL339549682M, tag identification 2360. | 0 000 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment | 02360 | | |

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| 02360 | Continued From page 1<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of two residents reviewed (R2) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |