Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL342325363M
Compliance #: HL342329165C

Date Concluded: January 31, 2024

Name, Address, and County of Licensee Investigated:
Mercy Link LLC
3149 Columbus Ave. South
Minneapolis, MN 55407
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 facility staff, abused a resident when the AP pushed the resident onto a bed during an altercation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to lack of documentation and conflicting information provided, it was unable to be determined if the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case manager. The investigation included review of the resident's medical record, personnel files, and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, depression, and anxiety. The resident's assessment indicated the resident was forgetful and had memory loss due to a traumatic brain injury (TBI). The resident's care plan indicated the resident required cues and reminders for dressing and grooming and staff managed the resident's medications.

Complaint documents indicated a staff member/alleged perpetrator (AP) pushed the resident after they refused to take a shower, which made the resident feel unsafe.

During an interview, the AP denied incident occurred and denied pushing the resident. The AP stated the resident had good hygiene practices and did not require reminders to take a shower.

Facility management was unaware of any concerns regarding the care provided by the AP. Facility management stated they met with residents on a weekly basis and were not aware of any physical altercations between staff and residents.

Attempts to contact the resident for interview were not successful.

During an interview, a family member stated they were informed of the alleged incident and had no concerns with the care provided at the facility.

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;

Vulnerable Adult interviewed: No, attempts to contact were successful.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided education to facility staff on de-escalation techniques and the treatment of vulnerable adults.

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
	34232	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY LINK LLC	3149 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 December 11, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL342325363M/ HL342329165C and #HL342326905M/ HL342323189C. No correction orders are issued.	0 000		