Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL345156563M
Compliance #: HL345159808C
Name, Address, and County of Licensee Investigated:
Derman Senior Care Inc.
2218 Doswell Avenue
St Paul, MN 55108
Ramsey County

Date Concluded: February 20, 2025

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, 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 facility and the alleged perpetrator (AP) neglected the resident when they failed to provide access to a telephone after the resident asked to make a personal phone call.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident was not able to make a phone call from the facility phone, there was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect. There were conflicting reports of what occurred and there was not enough specific information to determine if there was another working phone available to the resident.

The investigator conducted interviews with facility staff members, including administrative staff. The investigation included review of the resident record and facility policies and procedures. The investigator also toured the facility, observed staff interactions with residents and observations of care provided. The investigator spoke with local law enforcement officers, and reviewed video footage of the incident.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, antisocial personality disorder, and generalized anxiety disorder. The resident's service plan included reminders for activities of daily living, meal reminders, as well assistance medication management, housekeeping, and laundry.

The resident's assessment indicated that the resident had a history of verbal aggression and required behavior monitoring. The resident's assessment also indicated the resident was alert and oriented and able to make his needs known.

A review of complaint documents indicated concerns surrounding courteous treatment of the resident by the AP (facility administrator) at the facility and the accessibility to residents of a working telephone.

Video surveillance identified the AP and the resident interacting in a facility office space. The resident was seated behind a desk with a telephone receiver on the desk in front of him. The AP entered the room and picked up the handheld phone receiver. The resident made repeated requests to use the AP's personal cell phone, and the AP declined. The resident began yelling that there were no working phones at the facility and that he needed to make a personal phone call. The situation escalated until the AP began yelling at the resident to, "come out of my office, let's go outside!" Both parties then left the office and were seen and heard on video yelling at each other in the hallway over the availability of a working telephone.

During an interview, a facility administrator stated that there were two working phones in the common area of the facility at the time of the incident and denied having knowledge that either of the phones were inoperable at any time.

During an interview, the alleged perpetrator (AP), a facility administrator, stated he was unable to recall the specific interaction with the resident. The AP stated that the facility phones are always operational and denied knowledge that the phone available in the common area of the facility was not working.

During investigative interviews staff stated that the phone located in the common living area had been inoperable in the past but were unsure of the time frame and that the phone was replaced within the past few weeks. The phone was accessible and in working order at the time of the onsite visit.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, attempts to contact were unsuccessful
Family/Responsible Party interviewed: No;
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34515	A. BUILDING: _____ B. WING _____	C 12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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: On December 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL345159764C. No correction orders are issued. #HL345159808C/#HL345156563M On December 13, 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 104 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL345159808C/#HL345156563M, tag identification 2350.	0 000	Assisted Living Provider 144G. 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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02350	Continued From page 1	02350		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to treat a resident (R1) with courtesy and respect when a facility staff member, the alleged perpetrator (AP) was seen on a surveillance camera yelling at R1. 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 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). The findings include: R1's diagnosis included schizoaffective disorder, antisocial personality disorder, and generalized anxiety disorder. R1's service plan dated December 19, 2024, indicated R1 received services to include medication management, assistance with housekeeping, laundry, and safety checks. R1's Individual Abuse Prevention Plan (IAPP) dated November 22, 2024, indicated R1 is a vulnerable adult and is risk for abuse or neglect. Staff have been trained on signs and symptoms of abuse and neglect and should report immediately to registered nurse or director. The	02350		

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02350	Continued From page 2 IAPP indicated R1 had a history of verbally aggression, requiring staff to redirect the client and give him space to calm down. Video surveillance footage showed a verbal altercation between R1 and the AP, a facility administrator (AD)-B. The video was recorded by a facility camera placed in the upper corner of the administration office located on the 2nd floor of the facility and time stamped October 22, 2024, 12:32 p.m. The video footage shows R1 seated at a desk inside the facility office area on the second floor. R1 can be heard on video asking the AP (AD-B) to use a cell phone to make personal call. R1 stated, "phones don't work, there are no working phones here, I need to use a phone, can I please use your phone." After repeated requests by R1 to use a phone, the AP (AD-B) repeatedly points at the office doorway with a handheld phone in his hand while raising his voice and demands the resident leave his office. The verbal altercation extends into the common hallway where the AP (AD-B) and R1 continue to yell at each other over the availability of a phone. R1 can be again heard asking, "can I please use your phone", and the AP replies NO! During an interview on January 9, 2025, the AP (AD-B) stated that he did not recall this specific incident with R1. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 08, 2022, provided to staff during training and residents upon admission included residents	02350		

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02350	Continued From page 3 have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02350		