Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34744002M
Compliance #: HL34744003C

Date Concluded: April 8, 2022

Name, Address, and County of Licensee Investigated:
Suite Living of Little Canada
2740 Rice Street
Little Canada, MN 55113
Ramsey County

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

Evaluator's Name: Yolanda Dawson 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): The Alleged Perpetrator (AP) physically abused the resident when she engaged in a physical altercation with the resident, hitting him twice.

Investigative Findings and Conclusion:
Physical abuse was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP did not follow the resident's smoking agreement and the resident become agitated and aggressively approached the AP. The AP pushed the resident. As the altercation proceeded, the AP had repeated opportunities to safely exit the situation and instead the AP hit, threw objects at, and yelled at the resident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigator reviewed the AP's file, the resident's record, law enforcement report, facility video, and facility policies.

The resident resided on the memory care unit with diagnoses that included Wernicke's disease, restlessness and agitation, major depressive disorder, and anxiety disorders. The resident received services for medication management, reminders for activities of daily living, safety checks, and behavior management.

The resident's signed smoking agreement indicated the resident could request five cigarettes from the med-passer on the day shift 7:00 a.m. to 2:00 p.m. and five cigarettes on the evening shift 2:00 p.m. to 8:00 p.m. The resident could have a cigarette any time during those hours. When the five cigarettes on each shift were gone, staff would not provide any more cigarettes during that shift. The staff had a log sheet for the resident to sign when he received a cigarette to help him track how many cigarettes he had received.

One morning, the AP told the resident he would not be getting a cigarette at all on this day and would have to wait until the next day. The resident became upset and began acting aggressively towards the AP.

Video provided by the facility showed the incident took place in the early morning. The AP stated to the resident he would have to wait until the next day to have a cigarette. The resident became upset by this statement, approached the AP, and put his finger in her face. The AP pushed the resident, at which time the resident grabbed the keys the AP had in her hand. The AP responded by hitting the resident twice with another set of keys that were on a lanyard. The AP and the resident exchanged profanities and the AP threatened to harm the resident several times throughout the incident. Four times during the incident, the resident threw objects at the AP and the AP responded by throwing objects back at the resident. The video showed the AP had many opportunities to walk away from the altercation and did not do so.

Interviews and medical records did not indicate that the resident was injured by the incident.

The law enforcement report of the incident indicated the AP was charged with criminal abuse in connection with the incident.

During a phone interview, an administrative staff member stated there were cigarettes available for the AP to give the resident; on the day of the incident, the resident was not out of cigarettes. The administrative staff member stated another staff member reported the AP said she did not want to give the resident a cigarette because he was rude to her the day before.

In conclusion, physical 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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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: No, the AP declined to be interviewed.

Action taken by facility:
The AP is no longer employed by the facility.

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Little Canada City Attorney
Ramsey County Sheriff's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34744	A. BUILDING: _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF LITTLE CANADA	2740 RICE STREET SAINT PAUL, 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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL34744003C/#HL34744002M On March 17, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 27 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued. The following correction order is issued for #HL34744003C/#HL34744002M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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. This MN Requirement is not met as evidenced by: Based on interviews, video review, the facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. R1 was physically abused. Findings include: On April 8, 2022, the Minnesota Department of Health (MDH) issued a determination that physical abused 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	