Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36601001M
Compliance #: HL36601002C

Date Concluded: August 22, 2022

Name, Address, and County of Licensee Investigated:
Suite Living of Ramsey
7007 139th Lane Northwest
Ramsey, MN 55303
Anoka County

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

Evaluator's Name:
Maerin Renee, 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) physically abused the resident when she slapped the resident during cares.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP did not follow the resident's care plan when providing cares and the resident became agitated. Recorded video of the resident's room showed the AP forcibly restraining the resident with her hands and the resident was struggling with the AP. The AP attempted to provide cares to the resident after the resident repeatedly declined assistance. The AP was observed struggling with the resident for approximately 20 minutes, increasing the resident's agitation, and slapped the resident's hand during the struggle.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, employee personnel files, facility policies and procedures, and facility video of the incident. In addition, observations were made of the facility environment, staff and resident interactions, and staff providing cares to residents. No police report was filed.

The resident resided in an assisted living memory care unit and had diagnoses including dementia, urinary incontinence, and a history of hip fracture. The resident's service plan indicated the resident required staff assistance with dressing, grooming, toileting, transferring, meals, and medication management. The resident's assessment indicated resident was oriented to self only.

During an interview, a nurse stated the resident had a camera in his room and the videos were viewed frequently by the resident's family. The resident's family member reported recorded video of the AP slapping the resident during incontinence care. The nurse stated she and other staff members watched the video with the family member and saw the AP slap the resident's hand as he became agitated when the AP was attempting to assist the resident with cares. The nurse stated the AP was not providing cares to the resident according to the resident's plan of care. The AP was independently assisting the resident with cares and the resident required two staff members to assist with continence care. The AP also rolled the resident onto his right hip, which was broken at the time. The nurse stated this seemed to cause the resident increased pain and discomfort and triggered increased agitation.

When interviewed, management staff stated the AP worked full-time at a sister facility but had picked up a shift at the resident's facility and was familiar with the site. The administrator stated the AP admitted she had not read the resident's care plan before providing cares.

The video footage was reviewed and began with the AP entering the resident's room. The resident was calm, lying on his back in bed, and his hands were behind his head. The AP raised the head of the bed and the bed's knee section before raising the entire bed. The AP then rolled the resident onto his right side (the side of his broken hip). The resident repeatedly cried out in pain as the AP continued to change the pad and brief while standing on the left side of the bed. After several minutes, the AP pushed the resident's bed away from the wall to stand at the resident's right side. The resident was still rolled onto his right hip and did not want to roll over. The resident grasped the bed rail to prevent the AP from rolling him over, and the AP pried the residents hands off the bedrail. The resident continued to cry out as the AP attempted to roll him onto his left side. The AP continued to pry the resident's hands from the bed rail.

The AP began to scold the resident when he continued to struggle. The AP then forcibly held the resident's left arm onto the bed, pinning the resident in place. The AP grasped the resident's right hand for several minutes, until the resident managed to free himself. The resident's arms began to flail, and the AP struggled to manage his arms, saying, "I did not hurt you, but you're hurting me. If I did hurt you, it wasn't intentional," "I didn't bust your hip," and

"Dammit, I'm done!" The AP continued to attempt continence care as the resident yelled, "No, no, no, no." At one point the AP grasped both of the resident's arms in her hands and said, "Please let me help you," to which the resident replied, "No." The AP promised the resident she would get him pain medication, but never did so. The AP also threatened the resident by saying she was going to write an incident report stating the resident was "punching" and "smacking" her. The investigator did not witness the resident punch or smack the AP on the video, although it appeared he was attempting to swat her away as he continued to cry out in pain. At one point, as the resident reached for the AP, the AP slapped his left hand with her left hand. Throughout the incident, the AP would grasp the resident's hands to prevent him from moving. The AP eventually completed continence care, without the aid of a second staff member per the resident's care plan and left the room. The AP was observed struggling with the resident for approximately 20 minutes as the resident continued to refuse cares.

The AP did not respond to requests for interview.

Review of the AP's personnel file indicated the facility provided the AP with vulnerable adult training and supervised competencies upon hire, including personal cares and dementia training.

In conclusion, the Minnesota Department of Health determined 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, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP did not respond to requests for interview.

Action taken by facility:
Facility leadership viewed the video, and retrained staff regarding vulnerable statutes. 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.htmlIf you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 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
Anoka County Attorney
Ramsey City Attorney
Ramsey Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	C 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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, 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: #HL36601002C/#HL36601001M On July 15, 2022, 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 28 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL36601002C/#HL36601001M, tag identification 1460 and 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.	
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors	01460		

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01460	Continued From page 1 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure orientation to assisted living licensing requirements and regulations was provided for three of three employees (unlicensed personnel (ULP)-B, ULP-E, and ULP-F with records reviewed. This had the potential to affect all residents receiving services from the facility. 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 the residents). The findings include: ULP-B began providing assisted living services for the provider on August 1, 2021; however, ULP-B had a start date July 20, 2020, under the comprehensive home care license. ULP-B's employee records reviewed on July 15, 2022, did not have documentation to indicate the assisted living facility training requirements were completed in accordance with 144G statutes.	01460		

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01460	Continued From page 2 ULP-E had a start date of March 22, 2022. ULP-E's employee records were reviewed on July 15, 2022,. ULP-E's employee records did not have documentation to indicate the assisted living facility training requirements were completed in accordance with 144G statutes. ULP-F had a start date of April 18, 2022. ULP-F's employee records reviewed on July 15, 2022, did not have documentation to indicate the assisted living facility training requirements were completed in accordance with 144G statutes. On July 15, 2022, at 12:00 p.m., the investigator requested copies of staff 144G training. The housing director/ administrator (Admin)-C expressed lack of knowledge of 144G statutes. An employee orientation training policy titled Orientation of Staff and Supervisors & Content dated July 20, 2021, indicated staff must complete an orientation to Assisted Living licensing requirements and regulations before providing assisted living services to residents. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01460		
02360	144G.91 Subd. 8 Freedom from maltreatment 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:	02360		

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02360	Continued From page 3 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. Findings include: On July 15, 2022, 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	