Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36636001M
Compliance #: HL36636002C

Date Concluded: June 23, 2022

Name, Address, and County of Licensee Investigated:
Cedar Creek Senior Living
19131 Taylor Street
East Bethel, MN 55011
Anoka County

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

Evaluator's Name: Willette Shafer, 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 and emotionally abused the resident when the AP called the resident derogatory names on multiple occasions, threatened physical harm against the resident and was physically aggressive towards the resident.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator was responsible for the maltreatment. The AP emotionally abused the resident when the AP threatened physical harm against the resident, made disparaging and derogatory comments toward the resident, and grabbed the resident's arm forcefully. The incident was recorded by facility cameras.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility and observed interactions between staff and resident. The investigator reviewed medical records, facility policies, incident reports, grievances, and the internal investigation including camera footage of the alleged incidents. In addition, the investigator requested the police report.

The resident lived in the memory care area of the facility for one year prior to the incident due to diagnoses that included dementia and heart failure. The resident received services from the assisted living provider that included assistance with dressing, bathing, grooming, meals, housekeeping, and reminders.

The camera footage showed the resident sitting at a table eating with other residents. The AP called the resident “dirty” and told the resident “you don’t ever take a shower.” The AP grabbed the resident’s hand and pulled it down and the resident was able to free his hand, then the AP grabbed the resident’s arm and forcefully pulled it down next the resident’s wheelchair arm and held it there while she said, “I’ll kick your ass out of here.” She continued to tell the resident “I’ll have your ass kicked out by the cops.” The AP bent down and put her face a couple inches in front of the resident’s face and said, “I’ll call your daughter and tell her to get you the fuck out of here because you will not hit a woman because I will kick your butt, fucking asshole.”

During an interview, a nurse said she observed the AP get in the resident’s face, yell at him, and call him names. The nurse said the AP threatened to kick the resident out. The nurse reported the incident to management. The nurse said she observed the AP treat the resident poorly in the past. The nurse said the AP was dismissive and insulative towards the resident prior to this incident.

During an interview, management staff-1 said a nurse reported she observed the AP maltreat the resident. Management staff-1 watched the camera footage and said she observed the AP call the resident names, threaten the resident, and grab the resident’s arm roughly. Management staff-1 removed the AP from the resident care area. Management staff-1 conducted an internal investigation and concluded the AP maltreated the resident.

During an interview, management staff-2 said the AP completed training on maltreatment of vulnerable adults when she was hired. Management staff-2 said she watched the video and observed the AP call the resident derogatory names, threaten the resident with physical harm, and grab the resident’s arm.

During an interview, the AP said she told the resident not to touch the glasses because he was dirty. The AP said she spoke loudly because the resident is hard of hearing. The AP said she put her hands on the resident because he has been “pushy” in the past. The AP said she has received training on maltreatment of vulnerable adults and in dementia care. The AP said she

blames management for swearing at the resident and losing her job because they could have helped more.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(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 decline.
Family/Responsible Party interviewed: No, due to no further information to add.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and reported the incident to external sources. The facility completed re-education with all employees on maltreatment. The facility completed full body audit on memory care residents. The AP is no longer employed at 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

Anoka County Attorney
East Bethel City Attorney
Anoka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36636	A. BUILDING: _____ B. WING _____	C 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK SENIOR LIVING	19131 TAYLOR STREET EAST BETHEL, MN 55011

(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: #HL36636002C/#HL36636001M On May 26, 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 65 clients receiving services under the provider's Assisted Living Facility with Dementia Care license. The following correction order is issued for #HL36636002C/#HL36636001M, 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 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 June 23, 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. 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.	