Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368938942M
Compliance #: HL368936961C

Date Concluded: May 6, 2025

Name, Address, and County of Licensee Investigated:
Premium Health Care
7532 13th Ave South
Richfield, MN 55423
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Substantiated, individual responsibility

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 member, emotionally abused the resident when the AP grabbed a knife during an altercation, chased, and frightened the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP chased the resident through the kitchen of the facility with a knife in his hand.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The facility was a two-story residential home with a basement. The main level consisted of resident rooms, a living room, and a kitchen. The second level consisted of resident rooms, and the basement was used for facility staff.

The resident's diagnoses included schizophrenia and dementia. The resident's service plan included assistance with behavior management including agitation, anxiety, physical and verbal aggression, and paranoia. The resident was moderately cognitively impaired and became agitated easily. The resident's behavior care plan directed staff to approach the resident in a calm manner, redirect, and notify the supervisor when the resident became agitated and/or physically aggressive.

An incident report indicated one day the resident went into another resident's room. The AP heard the other resident holler and went to the room. The other resident explained that the resident was in her room. The AP went upstairs to the resident's room and when the AP got to the resident's room, the resident opened his door and spat at the AP. The AP returned to the main level living room and called the manager. The manager told the AP to calm down and the manager was on their way to the facility. During the conversation, the resident came from the kitchen to the living room, walked toward the AP who was on the couch, and spat at the AP. The AP grabbed an object and chased the resident. Emergency services were called.

Camera footage showed the resident walk through the kitchen, around a corner and into the living room. The AP can be seen sitting on the couch in the living room with a coffee table in front of him. The resident approached the AP, spat on the AP and took a couple steps backwards. The AP grabbed an object from under the coffee table, stood, and chased the resident through the kitchen. A second recorded camera footage showed the resident coming out of the kitchen, turning a corner, and running up the stairs to the second level. The AP can be seen running through the kitchen chasing the resident, turning the corner toward the stairs, and drop an object. The camera footage showed the AP pick the up object, a knife, off the floor and return to the kitchen.

The law enforcement report indicated the AP stated he was on the phone with his manager when the resident came into the living room upset about something. The resident spat on the AP and the AP admitted to chasing the resident up the stairs with a knife. The report indicated when law enforcement spoke with the resident, the resident was in his room with the door closed with a metal rod in his hand. The resident told law enforcement the AP chased the resident with a knife but did not touch the resident with the knife. The AP was arrested on fourth degree assault on a vulnerable adult.

During an interview, leadership stated the knives should be locked in a cabinet in an office when not in use. Leadership stated knives were not supposed to be in the living room and was not sure how a knife was in the living room on a shelf on the coffee table. The AP was no longer employed at the facility.

During an interview, the director stated the AP had training on how to de-escalate resident behaviors, approach a resident in a calm manner, and not to argue with the residents. The AP should have tried to calm the resident down and offer as needed medications. The director stated the AP called the manager for assistance with the resident's behavior. The AP should not have chased the resident with a knife.

The AP declined an interview.

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: …
(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. No longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Declined an interview.

Action taken by facility:
The facility ensured staff were at the facility when the AP was arrested to continue providing care to the other residents.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

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
Hennepin County Attorney
Richfield City Attorney
Richfield Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36893	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HEALTH CARE INC	7532 13TH AVENUE SOUTH MINNEAPOLIS, MN 55423

(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: #HL368938942M/#HL368936961C On April 22, 2025, 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 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL368938942M/#HL368936961C, tag identification 2360.	0 000	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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: The facility failed to ensure one of one resident (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		