Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL386811420M
Compliance Project: HL386812123C

Date Concluded: July 11, 2025

Name, Address, and County of Licensee Investigated:
Open Arms Senior Living
4414 Martin Road
Rice Lake, MN 55803
St. Louis County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 alleged perpetrator (AP), a facility staff member, abused the resident when the AP threw the resident's legs into the bed after the resident hit the AP in the face while providing care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP denied abusing the resident and the video provided did not have a clear view, making it unable to determine if abuse occurred. The AP said she was hit in the face by the resident. The AP and two other unlicensed personnel (ULP) did not use proper technique for positioning but in an attempt to provide the safest care for the resident with the bed in the low position.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel files, staff

schedules, and related facility policy and procedures. Also, the investigator observed facility staff and resident interactions during an onsite visit.

The resident resided in a secured dementia care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with transferring, bed mobility and incontinence care. The resident's assessment indicated the resident had cognitive impairment with, at times, known verbal and physical aggression.

A facility internal investigation indicated after review of video footage from the resident's room, the AP appeared to forcefully move the resident's legs to the middle of the bed, during incontinent cares. The facility suspended the AP and began an investigation.

Review of the video showed three staff members in the resident room; the AP alone on one side of the bed on her knees as the bed was in the lowest position to the floor, and unlicensed caregiver #1 and unlicensed caregiver #2 on the other side of the bed with their backs to the camera. They began by unlicensed caregiver #1 explaining what cares they were about to provide, upon rolling the resident, he began yelling out. Unlicensed caregiver #2 held the resident's hands and unlicensed caregiver #1 was holding the resident's legs while the AP was providing peri care after an incontinent episode. Upon rolling the resident, unlicensed caregiver #2 stopped holding the resident's hands and stepped back, and the AP stated, "please stop hitting me in my face." It was unable to determine if the resident hit the AP, as the camera view was blocked by the other caregivers. When rolling the resident back to the middle of the bed, the AP appeared to roll the resident's legs back swiftly.

During an interview, unlicensed caregiver #1 stated she was called in to help with cares as the resident was yelling out and trying to strike the caregivers while providing incontinent cares. She went on to state she felt the AP was frustrated while providing cares and after she was hit may have rolled the resident back "pretty hard." Unlicensed caregiver #1 said the AP was very blunt and direct when talking to residents.

During an interview, unlicensed caregiver #2 stated the resident became aggressive when she and the AP were attempting to provide incontinent cares, so they called in unlicensed caregiver #1 to help. She and unlicensed caregiver #1 held the resident's hands while AP cleaned the resident. After rolling the resident, the AP yelled out, "he punched me." Unlicensed caregiver #2 said they finished cares very quickly after that.

During an interview, the AP stated two to three staff were needed to change the resident when incontinent. Three staff were needed for resident and staff safety due to intermittent agitation. The AP stated that she was on her knees at the side of the bed that was low to the floor, they did not raise the bed because the resident had rolled out of bed on previous occasions. When the resident was turned back towards the AP, the other two staff members let go of the resident's hands and the AP was hit in the face. The AP reported when she was hit it "dazed

her” and continued to state she moved the resident’s legs over quickly for his safety and to get herself out of the way so she did not get hit again.

In conclusion, the Minnesota Department of Health determined abuse 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.

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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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: No, the resident is deceased
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility investigated the incident, the AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	38681	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS SENIOR LIVING	4414 MARTIN ROAD DULUTH, MN 55803

(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 On May 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL386812123C/#HL386811420M. No correction orders are issued.	0 000		