Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL395412023M
Compliance #: HL395413435C

Date Concluded: May 20, 2025

Name, Address, and County of Licensee Investigated:
Alabama Residence
14438 Alabama Ave S
Savage MN 55378
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier
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 facility abused the resident when it locked the brakes on the resident's wheelchair rendering it unmovable for the resident.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. The investigation was unable to demonstrate the locking of the wheelchair to punish the resident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with residents, visitors and other staff members.

The resident resided in an assisted living facility. The resident's diagnoses included a cardiovascular event and mental health issues. The resident's service plan included assistance

with daily grooming, mobility, medication management and transferring. The resident's assessment indicated the resident used a wheelchair and had limited mobility.

A concern arose a staff member locked the resident's wheelchair, making the resident immobile possibly as a form of punishment.

During an interview, the resident stated there were times the facility staff members locked the resident's wheelchair so it could not be moved. The resident stated this made her feel bad.

During an interview, a second resident stated they had not observed staff members locking wheelchairs. The second resident stated they spent a lot of time with the resident.

During an interview, a nurse stated staff members would not lock any residents' brakes on a wheelchair. The nurse stated the resident was free to move around in the facility.

During unannounced onsite visits, the investigator observed the resident in the wheelchair however it was not to be locked on those occasions.

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:
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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: NA
Alleged Perpetrator interviewed: None identified.

Action taken by facility: No action required.

Action taken by the Minnesota Department of Health: No further action 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
	39541	A. BUILDING: _____ B. WING _____	C 04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA RESIDENCY	14438 ALABAMA AVENUE SOUTH SAVAGE, MN 55378

(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 April 28, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL395413435C/#HL395412023M. No correction orders are issued.	0 000		