Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396675061M
Compliance #: HL396676648C

Date Concluded: November 7, 2024

Name, Address, and County of Licensee Investigated:
Grace Assisted Living
7007 Greenbriar Curve
Shakopee, MN 55379
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Julie Serbus, RN
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 abused the resident when the alleged perpetrator locked the door to the resident's room secluding the resident in her room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While the resident's door was locked and needed to be unlocked it is not evident if the resident or staff had locked the door.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager. The investigation included review of the resident record including assessments, service plan, contract, resident notes, and related facility policies and procedures. Also, the investigator observed staff interactions with the resident including interventions.

The resident resided in an assisted living facility. The resident's diagnoses included vascular dementia. The resident's service plan included assistance with activities of daily living, medication management, behavioral management, and safety checks. The resident's assessment indicated the resident is at risk of elopement and wandering, at risk to be abuse and abuse others, and has impaired judgment. The resident displays behaviors to include agitation, physical and verbal aggression, and destruction of property.

One evening an unlicensed caregiver assisted the resident to her room for bed. When exiting the resident's room, the unlicensed staff locked the door by turning the lock from the inside of the door causing the door to the resident's room to lock.

The resident's progress note included documented notes regarding the report of the locked door indicated the resident had been outside with her family member. The resident was assisted to her room by unlicensed caregiver and family member. The note indicated the resident often "fiddles" with the interior lock on her bedroom door causing it to lock. The same note indicated staff members are aware and keep the key within reach to quickly unlock the door when this occurs. Additionally, the same note indicated the resident can also unlock the door herself and has done this in the past.

During an interview, a manager stated they received a call that evening from the unlicensed caregiver explaining the events. The manager stated the family member was at the facility and was extremely upset stating the caregiver had locked the resident in her room.

During an interview, a nurse stated the facility does not lock the resident's door to her room. The resident is free to wander throughout the facility. The nurse stated to the family member the regulation requires each resident door is required to have a lock.

During an interview, an unlicensed caregiver stated the resident had previous episodes of the resident locking her own door as she would play with the lock.

During an interview, the alleged perpetrator denied locking the resident's door. The alleged perpetrator stated the resident has a history of behaviors to include locking and unlocking doors. The alleged perpetrator stated staff members check on the resident often and would be aware if the resident had locked the door. The alleged perpetrator stated she has been trained on behavioral management and interventions when behaviors occur.

During an interview a family member stated he was at the facility, the resident was assisted to her room for bed, and when a staff member went to close her door, he heard the door lock click as staff closed the door. Shortly after the door was closed the family member stated he heard the resident hitting the door. The family member stated the staff member(s)had to use a key to unlock the door. The family member stated he was concerned, left the facility immediately, and returned shortly to remove the doorknob and place a new unlockable doorknob on the resident's door to her room.

In conclusion, the Minnesota Department of Health determined abuse is 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.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: No action taken.

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
	39667	A. BUILDING: _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	7007 GREENBRIAR CURVE SHAKOPEE, MN 55379

(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 October 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396677021C/#HL396675202M. No correction orders are issued. Additionally, on October 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396676648C/#HL396675061M. No correction orders are issued.	0 000		