Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204513441M
Compliance #: HL204513650C

Date Concluded: July 15, 2024

Name, Address, and County of Licensee Investigated:
Pearl Garden
3700 Foss Road NE
St. Anthony, MN 55421
Hennepin County

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

Evaluator's Name: Brandon Martfeld, 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 hit the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information provided, it could not be determined whether the alleged incident did or did not occur. The resident reported that the AP hit her, and the AP denied hitting the resident. There were no witnesses of the alleged incident. During a skin assessment the following morning after the alleged incident, the resident was found with a bruise to the back of her head and a bruised ring finger. It could not be determined whether the injuries occurred by the AP hitting the resident or the resident's multiple falls prior to the allegation and a fall later that night after the allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with fall risk preventions, toileting, and dressing. The resident was deaf but could communicate by reading lips and would answer questions that were written out. The resident's vulnerability assessment indicated the resident had areas of concerns for abuse and that staff was trained to observe for signs and symptoms and report immediately any concerns of abuse.

The facility investigation indicated unlicensed personnel notified the on-call nurse that the resident reported someone grabbed her arm and had a hand on her throat. During an interview with nursing leadership, the unlicensed personnel indicated the AP brought the resident to a common area by the nurse's station. The unlicensed personnel stated the resident mouthed the words "help me" and "was shaking" and stated she was "scared of her [AP]." The unlicensed personnel asked the AP if she hit the resident. The AP stated no, you know the resident does not like me.

During an interview with nursing leadership, another unlicensed personnel stated the resident waved her over and stated, "that girl over there" and pointed to the AP and stated, "she hit me."

During an interview with nursing leadership the following day, the resident denied being hurt. When the resident was asked if someone hurt you yesterday, the resident stated not last night.

An incident report indicated approximately one hour after the resident reported she was hit; the resident had an unwitnessed fall. The incident report indicated the resident had no injuries from the fall.

The morning after the resident reported being hit, the facility completed a skin check and found the resident with a bruise to the back of her head and a bruise to her ring finger.

Approximately two weeks prior to the incident, the resident's assessment indicated the resident had a bruise to the back of her head.

During an interview, unlicensed personnel stated the resident told her that the AP hit her with a pillow on her head. The AP denied hitting the resident and stated the resident hit her. The unlicensed personnel stated she looked at the resident's head and did not see a bruise.

During an interview, the other unlicensed personnel stated when the AP brought the resident out to the common area, the resident was very upset, and her face was red. The unlicensed personnel stated she did not see any bruises or specific redness to indicate the resident was hit or slapped.

During an interview, nursing leadership stated they found out about the incident the next morning. The AP was suspended during the investigation. The resident was found with a bruise to the back of her head. The resident did have a fall after making the allegation of being hit by the AP. The resident also had a bruised ring finger, and a couple of staff stated the bruise was older. Nursing leadership stated no one witnessed the AP hit the resident and the resident's room did not have a camera. Nursing leadership stated they had no evidence that the AP did or did not hit the resident.

During an attempted interview, the AP denied working at the facility.

During an attempted interview, the resident was incoherent.

During an interview, a family member stated the resident had dementia. The resident talked about different things that were not coherent. The family member stated they were unsure if the resident was abused.

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

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP declined to interview.

Action taken by facility:
The facility completed an internal investigation and staff were re-educated on reporting abuse immediately. The AP is no longer employed by 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
	20451	A. BUILDING: _____ B. WING _____	C 06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL GARDEN	3700 FOSS ROAD NE MINNEAPOLIS, MN 55421

(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 June 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL204513441M#HL204513650C. No correction orders are issued.	0 000		