Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL206192480M
Compliance #: HL206191589C

Date Concluded: July 2, 2024

Name, Address, and County of Licensee Investigated:
Ridgeview Senior Living
1009 10th Ave NE
Sauk Rapids, MN 56379
Benton County

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

Evaluator's Name:
Jana Wegener, RN, 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 resident was abused when the alleged perpetrator (AP) was observed on video surveillance following the resident in close proximity causing agitation. The AP grabbed the resident and pulled the resident to the couch and then the ground, and physically restrained the resident using the weight of her body and a bear hug for several minutes while the resident fought to get away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was observed on video pursuing the resident in close proximity causing agitation as the resident repeatedly tried to get away from the AP. Then, the AP grabbed the resident and forced the resident onto the couch where the AP physically restrained the resident for several minutes using her arms, legs, and weight of her body causing the resident distress. The AP continued to restrain the resident until separated by another staff. The AP admitted to restraining the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident’s family member. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, facility video surveillance, personnel files, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident’s and staff in the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including Alzheimer's disease, impaired memory, and generalized anxiety disorder.

The resident’s assessment indicated the resident had severe cognitive impairment, wandered, and required a secure memory care unit. The assessment indicated due to advanced dementia the resident did not always understand what was being asked and was not able to respond or answer appropriately. The assessment identified the resident showed signs of distress by having tense body language, pacing, and fidgeting.

The resident’s care plan/service agreement indicated the resident was ambulatory but needed redirection, reorientation, and reminders as needed. The care plan indicated staff completed behavior monitoring for verbal aggression and directed staff to provide non pharmalogical interventions including music, redirect to her room, television, and give her a stuffed dog. The care plan indicated if non pharmalogical interventions failed staff should administer as needed (PRN) medications. The care plan indicated if the resident was resistant staff should reapproach.

The resident’s service delivery record indicated staff were directed to monitor the residents behavior each shift. The behavior monitoring documentation the day of the incident lacked documentation of behavioral concerns for the resident prior to the incident and indicated the resident had done lots of wandering that day but was in good spirits.

The resident’s medication administration record (MAR) indicated the AP documented administering PRN Risperidone 0.25 at 3:46 p.m. for behavioral disturbance and documented the results were effective at 7:50 p.m. (almost 2 hours after the incident occurred). The resident’s MAR included other PRN medication for behavioral disturbances including Depakote 100 mg every 4 hours PRN, but the MAR indicated the medication was not utilized the day of the incident.

The progress notes included documentation the resident wandered and had verbally aggressive behaviors after admission to the facility. The progress notes indicated the resident’s behaviors had been improving after admission with one episode of striking out at staff in response to being startled which was an isolated incident. The resident’s progress notes the day of the incident lacked documentation of behaviors or interventions provided prior to the resident being restrained by the AP. Following the incident, a progress note indicated the resident was

transferred to the hospital by ambulance for becoming aggressive and violent towards staff posing a safety risk to staff and residents.

A facility incident report indicated the AP reported the resident became increasingly agitated for no apparent reason. The incident report indicated the AP tried to calm the resident down and keep her away from other residents, but the resident swore at the AP, bit the AP, and threatened the AP's life. The incident report indicated the AP called 911 and the resident's family member. The incident report lacked documentation the AP restrained the resident.

A facility investigation indicated at 6:06 p.m. the AP was observed on video following the resident in very close proximity around the common space for approximately 4 minutes. During that time the AP was observed toe to toe with the resident and stepped in front of the resident preventing the resident from moving freely through the common space. The investigation indicated during the encounter the AP was observed forming a fist by her side. The AP was observed aggressively forcing the resident to sit on the couch, where the AP began physically restraining the resident using a bear hug-type hold at 6:10 p.m. The resident was observed resisting the AP's restraint by pushing at the AP's arms, kicking at the AP, and bit the AP as the resident struggled to get away. The situation escalated, resulting in both the AP and resident falling to the floor, at which point another staff member intervened and separated them. The investigation indicated the AP restrained the resident until 6:14 p.m. (approximately 4 minutes). The investigation indicated the AP reported the resident made threats against her life justifying her actions as necessary to protect herself and other residents. However, the investigation indicated the video footage did not support the AP's claim because the resident possessed no weapons, and the other residents appeared unaffected.

When the investigator reviewed the video footage (no audio) the AP was observed closely follow the resident in the common area for several minutes prior to the incident which appeared to cause agitation for the resident. The resident was observed repeatedly trying to get away from the AP, and motioned/pointed for the AP to go away, but the AP refused and persistently pursued the resident in an intimidating manner. The AP was observed to have threatening body language with an expression of anger on her face and clenched fists at her side while standing toe to toe as she appeared to get in the resident's face. Then the AP aggressively grabbed the resident by the arms and forced the resident to a seated position on the couch. The AP was observed physically restraining the resident by wrapping her arms and legs around the resident and used the weight of her body on top of the resident to hold the resident down against her will as the resident struggled and fought against the AP to get away. The AP continued to restrain the resident until both the resident and the AP fell onto the floor where the AP continued to restrain the resident until separated by another staff. When the resident was released from the AP's restraint, she made no attempt of physical aggression toward residents or staff, wandered off, and then calmly sat in a recliner in the corner of the room. At no point was the resident observed to be physically aggressive or a danger toward other residents of the facility. The resident was not observed to be physically aggressive toward the AP until after the AP restrained the resident.

An email statement from the AP to facility leadership indicated when the AP's coworker left the unit to bring back a food cart the resident spoke aggressively and made threats toward the AP, so the AP had the resident "sit down on the sofa to calm down." Then, the resident began hitting the AP, and bit the AP's hand, while the AP held the resident's arms to keep the resident contained. The AP's statement indicated she restrained the resident to prevent the resident from possibly hitting another resident. However, the AP's statement indicated there was no physical aggression prior to being restrained by the AP, and the resident had made no attempts to harm another resident.

When interviewed unlicensed personnel (ULP) working with the AP at the time of the incident stated the resident had verbal behaviors but was not physically aggressive and was able to be redirected. The ULP stated the resident had no behavior concerns when she left the unit just before the incident occurred. Then, the AP called over the walkie and stated, "she hit me!" When the ULP asked the AP who hit her, the AP did not respond so the ULP hurried back to the unit. The ULP stated when she entered the unit, she could hear the AP and the resident yelling, then observed the AP with her arms wrapped around the resident holding the resident down on the couch. The ULP stated as the resident and AP struggled both of them fell to the floor while the resident repeatedly yelled out "Help, help, help!" The ULP stated the AP reported the resident was "getting aggressive", and "tried taking a swing at her". The ULP stated the resident appeared distressed and scared while she yelled and fought against the AP's physical restraint.

When interviewed multiple staff stated although the resident had verbal behaviors, she was not physically aggressive toward other residents, and was redirectable. Staff interviewed indicated when behaviors occurred, they would try non pharma logical interventions, give her space, reapproach, administer PRN medications, and contact the resident's family. Staff indicated if a resident was in danger of hurting themselves or someone else, they would call 911, but indicated at no point was it acceptable to restrain a resident. Staff interviewed indicated the AP had a short temper, with a pushy, forceful, aggressive demeanor which could trigger or increase behaviors in residents. Staff indicated when the AP was coached on her conduct with residents, she was resistive and defensive.

When interviewed leadership staff stated when they reviewed the video surveillance of the incident at no point was the resident aggressive towards other residents, and the resident was not aggressive toward the AP until after the AP forcibly restrained the resident. Leadership staff stated the AP provoked/antagonized the resident by persistently following her, then restrained the resident as the resident fought to get away.

When interviewed the resident's family member stated the resident was new to the facility, and staff were strangers to her at the time the incident occurred. The family member indicated having a stranger pursue the resident in close proximity, restrict her movements, then physically restrain her would have been frightening and distressing for the resident.

When interviewed the AP stated the resident made verbal threats against her so she "contained" the resident on the couch. The AP admitted restraining the resident but denied any wrongdoing.

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:
(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;
(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; and

Vulnerable Adult interviewed: No, not interviewable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended the AP, reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), investigated the incident, and provided all staff retraining on dementia care following the incident. The AP is no longer employed by the facility.

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.

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
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(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: #HL206192480M/#HL206191589C On June 10, 2024, 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 42 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL206192480M/#HL206191589C, 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

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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: Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		