Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211411380M
Compliance #: HL211412020C

Date Concluded: June 10, 2025

Name, Address, and County of Licensee Investigated:
Emerald Crest of Burnsville
451 E Travelers Trail
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 alleged perpetrator (AP), a facility staff member, abused the resident when the AP was shown on video restricting the resident's movement, hitting the resident and then pointing and yelling at the resident.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. A video showed the AP step in-between the resident and a second resident which was appropriate. At that point, the resident hit AP. However, abuse occurred when the AP raised her right arm and struck back at the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident and facility staff interactions during an onsite visit.

The resident resided in assisted living secured dementia care unit. The resident's diagnoses included dementia, anxiety, chronic pain and a history of a right below the knee amputation. The resident's service plan included assistance with transferring and behavior monitoring. The resident's assessment indicated the resident was confused, but able to express some needs and able to propel self in wheelchair.

A four-minute and seventeen second video provided by the facility showed an interaction between the AP and the resident. The video did not include audio but recorded the communal area identified as the living room.

At approximately the two-minute mark on the video, the resident was shown self-propelling in his wheelchair across the room where the AP was standing with her back to the resident, leaning against a recliner where another resident sat watching television.

At approximately the two-minute and ten second mark, the resident stopped and turned towards the AP. The AP then backed up facing the resident.

At approximately the two minute and twenty-five second mark the resident was propelling towards the area of a second resident and the AP stepped in front of the resident and blocked his path to the second resident.

At approximately the two minute and thirty-one second mark, the resident raised his left arm and hit the AP in the abdominal area. The AP raised her right arm above her head and swiftly lowered her right arm towards the resident and stepped in his direction. The resident raised his left arm and blocked the AP's arm.

The next thirty seconds of the video showed the AP with her finger pointed at the resident and appears to be speaking, however the video did not contain audio.

At approximately the three minute and twenty second mark, the resident self-propelled to dining room in front of kitchen counter and AP went into kitchen area.

During an interview, the AP stated that day the resident was agitated as he thought the other residents were in his home without permission. The AP stated she stepped in front of the resident's wheelchair to block him from confronting another resident but denied hitting the resident. The AP stated she was aware there were video cameras in areas of the facility.

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:
(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

Vulnerable Adult interviewed: no, resident has cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility completed an internal investigation, suspended and later terminated the AP, reported the incident to the state agency and provided re-education and training to the employees at 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.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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
Dakota County Attorney
Burnsville City Attorney
Burnsville Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21141	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF BURNSVILLE	457 EAST TRAVELERS TRAIL BURNSVILLE, MN 55337

(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: #HL211412020C/#HL211411380M and #HL211414587C/#HL211412622M On May 13, 2025, 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 59 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL211412020C/#HL211411380M and #HL211414587C/#HL211412622M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and one individual person was responsible for the maltreatment that occurred during one incident, while a second person was responsible for a separate incident..Both incidents occurred at the facility. Please refer to the public maltreatment reports for details for each respective resident.	02360		