Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211412622M
Compliance #: HL211414587C

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), an unlicensed caregiver, abused the resident when she hit the resident with a water pitcher and a Hoky (a metal rug sweeper) during a physical altercation between the two.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Although both the AP and the resident participated in the physical altercation, the AP abused the resident when she used a Hoky and a plastic water pitcher to hit the resident repeatedly as shown by video provided by the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report with on scene "body cam" videos, facility surveillance videos, and related facility policy and

procedures. Also, the investigator observed interactions between facility staff and residents during an onsite visit.

A concern arose when an incident was reported to the nurse that the resident had thrown water at the AP and later hit another resident with a Hoky causing a head laceration. The AP notified the nurse that emergency medical services (EMS) had been called due to the injury to the other resident.

Two days later as part of the facility investigation, the nurse reviewed camera footage with the intent of identifying any precipitating factors or triggers for the resident's behavior. The nurse reviewed the video footage, identifying events on the video initially not disclosed by the AP about the physical altercation between the resident and the AP.

The resident resided in an assisted living secure dementia care unit. The resident's diagnoses included neurocognitive disorder, history of traumatic brain injury, and history of urinary retention. The resident's service plan included assistance with medication management and behavior monitoring. The resident's assessment indicated the resident had severe cognitive impairment, however the resident was able to walk independently.

The resident's medical record indicated a history of agitation with increased behaviors when he experienced an inability to urinate. The same documents indicated he had a specific behavior of throwing water at staff members at times. The suggested interventions on the plan of care included redirection and escorting the resident to his room.

During an interview, the AP stated she had worked at the facility for more than three years and mostly worked in the afternoons. The AP stated the resident was known to have behaviors, including agitation but normally he listened to her and was redirectable.

The video footage provided by the facility included two videos, a two minute fifteen second video of the dining room and kitchen area and second video of the hallway that views a hallway and the edge of the kitchen counter and entrance to the kitchen. The second video is two minutes and forty-nine seconds in length.

Dining room video

A video showing the facility dining room was reviewed; the following events at the approximate time stamps are listed below.

The camera view showed a dining room with double doors at the left to enter from a side room and with the kitchen at the back of the view. The kitchen area was separated from the dining room area by a countertop with a walkway on the left. Additionally, there was a hallway by the kitchen that led out of view to both the left and right of the kitchen.

For the time reviewed, initially the AP was behind the counter in the kitchen area. A plastic pitcher was on the counter while five other residents are in the dining room area seated at tables for the evening meal.

- 17:37:57 the resident entered the dining room and walked to the kitchen, he appears to lift right arm as if to throw something in direction of the AP. [The video skipped approximately six seconds, and the resident had exited the room].
- 17:38:13 the resident entered the dining room through the double doors, then walked toward the kitchen with a plastic cup in his hand. The AP was in the kitchen area and the plastic pitcher was on the kitchen counter.
- 17:38:17 the AP walked quickly across the kitchen towards the right and picked up a Hoky, which had been out of view until this time.
- 17:38:19 as the resident reached for the plastic water pitcher, the AP simultaneously swung the Hoky at the resident hitting his right arm.
- 17:38:21 the resident backed away from the counter with the water pitcher in his right hand, while the AP stepped toward the resident swinging and hitting the resident with the Hoky. Meanwhile a second female resident came from behind the resident and held the resident's upper arms from behind.
- 17:38:35 the AP continued to swing the Hoky at the resident, hitting the resident's head and body multiple times.
- 17:38:40 a second caregiver entered the camera view and attempted to step in between the resident and the AP. The AP took the plastic pitcher from the resident and hit him on the left side of his head. The AP and the resident continued to struggle over the Hoky.
- 17:38:56 the second caregiver went into the kitchen to use the phone to call for help. The AP continued to struggle with the resident over the Hoky.

Hallway video

A video showing the hallway near the kitchen was reviewed and showed the following events at the approximate time stamps listed below.

- 17:38:19 the video showed the resident pick up the plastic water pitcher off the kitchen counter, and the Hoky come into view hitting the resident's arm. The AP walked out of the kitchen towards the resident and swinging the Hoky at the resident.
- At 17:38:56 the AP and the resident enter the video frame struggling over the Hoky. The AP pushed the resident up against the wall while still struggling for the control of the Hoky and continued down the hallway towards the camera. The second female resident followed closely behind.

- 17:39:12 the AP reached up and pushed the resident's face forcefully with her left hand. The resident wrestled the Hoky away from the AP, then quickly turned and left out of camera view. The AP walked back towards kitchen area also leaving view of the camera.

A police report indicated they were dispatched to the facility due to a resident-to-resident altercation involving a resident. The AP reported to police the resident approached her and threw water at her, so she picked up the Hoky to keep him back from her. The AP stated the resident twisted her arm taking the Hoky sweeper from her. The AP went on to report the resident then hit another resident with the Hoky causing a forehead laceration injury to the other resident [which was why the police were summoned].

The same police report indicated when approached, the resident followed directions and was cooperative, however was breathing heavily and was not verbally responding. The resident was transported to the hospital for evaluation.

The police body cam video shows the resident cooperating with police officer, showing the police officer areas injured and bleeding to his right arm.

A second police body cam showed the AP, stating the resident threw the pitcher of water on her then she used the Hoky to defend herself.

During an interview, the AP stated she used the Hoky to keep the resident from getting closer to her. The AP stated that the day before the incident the resident had increased agitation, requiring additional medication. The AP stated she did not pick up the Hoky with the intention to hit the resident but grabbed it to keep the resident away from her. She denied hitting the resident. The AP stated she had not seen the facility video. The AP stated she was suspended immediately and later her employment was terminated.

During an interview, the second caregiver who witnessed a portion of the altercation stated she returned from her break and was confused by what she saw. She stated she felt if the AP would have stopped struggling with the resident, the situation could have been diffused.

While at the hospital the resident was diagnosed with urinary retention, treated, and returned to the facility two days later.

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
(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, unable due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: Facility leadership completed an internal investigation. The AP was suspended and no longer employed at the facility. Additional training and education related to vulnerable adult abuse was provided to unlicensed caregivers.

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		