Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273781664M
Compliance #: HL273783246C

Date Concluded: April 19, 2023

Name, Address, and County of Facility Investigated:
Inver Grove Heights White Pines II LLC
9058 Buchanan Trail
Inver Grove Heights, Minnesota
55076-3554
Dakota County

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

Evaluator's Name: James P. Larson
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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.

Allegation(s):
A staffing agency unlicensed personnel (ULP)/ alleged perpetrator (AP) and additional unknown facility staff emotionally abused the resident when they yelled at the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the alleged perpetrator's (AP) actions were disrespectful and unprofessional, there is not a preponderance of evidence it met the definition of abuse. The AP acknowledged the verbal altercation occurred but denied the use of profanity. It is unknown if the second reported incident of shouting involved staff or other residents. There was no witness to the incident and no AP was identified.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also conducted an interview with the resident's family. The

investigation included review of the resident's medical record, nursing assessments, service plans, care plans, and progress notes. The investigator conducted an onsite visit and observed staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included nontraumatic subarachnoid hemorrhage, intellectual disabilities, impulsiveness, nicotine dependence. The resident's service plan included assistance with medication administration, activities of daily living, housekeeping, and meals.

The resident's assessment, completed prior to the incidents, indicated the resident had a history of impulsiveness which included verbal outbursts and physical altercations with caregivers. Review of the resident's medical record indicated an ongoing fixation and obsessive behaviors surrounding the use of tobacco products. Interventions were in place to assist in redirection of the resident and scheduling techniques as needed.

A review of a facility incident report of the first witnessed incident indicated that an agency unlicensed personnel (ULP)/alleged perpetrator (AP) was involved in a verbal altercation with the resident and was heard saying to the resident, "Get the (expletive) out of here, go to your room!" The witness reported to the licensed assisted living director (LALD) that the resident then left the immediate area and went outside via the patio door where he slammed the door behind him as he exited. The AP was then witnessed shouting, "I don't care if you break the (expletive) door!".

During an interview with the AP, they recalled the verbal altercation with the VA, although denied the use of profanity.

Further review of the resident's electronic health record (EHR) progress notes indicated an unwitnessed verbal incident took place months later. The resident was described one evening as becoming loud, spitting, and inappropriately touching staff. After notifying the nurse of a change in behavior, the ULP was directed to contact Emergency Medical Services (EMS). The resident was brought to a local hospital for evaluation where he was diagnosed with a urinary tract infection (UTI). The resident was prescribed an antibiotic and returned later that same evening to the facility.

During an interview with the Assisted Living Director (LALD) , she stated the facility conducted an internal review of events and were able to verify a witness to the first event and named an AP. Actions were taken immediately and the AP was relieved of duty and removed from the facility. The second event was unwitnessed, and an AP was not identified.

Following these incidents, facility nursing staff offered additional training and interventions to ensure the resident's safety.

During an interview, the resident indicated he had no concerns with the care provided at the facility and could not recall the incidents.
During an interview with a resident's family member, they stated they had not visited the facility but had no concerns over the resident's care.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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;
(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
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility had the identified AP removed from the facility and reported the incident to MDH and the staffing agency.

Action taken by the Minnesota Department of Health:

No further action.

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
	27378	A. BUILDING: _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(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 April 10, 2023, the Minnesota Department of Health initiated an investigation of complaint HL273783246C / HL273781664M No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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	

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0 000	Continued From page 1	0 000	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	