Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282044524M
Compliance #: HL282047776C

Date Concluded: July 3, 2023

Name, Address, and County of Licensee Investigated:
Hometown Senior Living Wedgewood
3610 Mount Vernon Court
Woodbury, MN 55129
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 alleged perpetrator (AP) physically abused a resident when the AP hit the resident in the face twice, resulting in bruising to the resident's left eye and cheekbone.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was witnessed on recorded video hitting the resident two times in the face when providing cares. The resident developed bruising around his left eye and cheekbone.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and law enforcement. The investigation included review of the resident's medical chart, the AP's personnel file, policies and procedures, recorded video, the police report, and the internal

investigation. Also, the investigator observed staff providing cares and interacting with residents.

The resident resided in an assisted living memory care unit with diagnoses including dementia, and diabetes type 2. The resident's service plan included assistance with bathing, grooming, dressing, transfers, meals, laundry, housekeeping, and medication management. The resident's assessment indicated the resident was hard of hearing, easily startled, and was at risk for falls.

The facility investigation indicated the AP was witnessed on video in the resident's room aggressively rolling the resident from side to side in bed, and the AP also hit the resident in the face twice. When interviewed, the AP stated the "flip" (turning the resident in bed) looked aggressive because the resident was fighting the flip, so the AP had to put more force into it. The AP stated the resident grabbed some of his hair and "ripped" it out of his scalp. The AP stated he "swung" at the resident with his fist to get the resident's hands off his hair. The AP stated he "smacked" the resident in the face again but stated he "just nipped his [the resident] chin."

Review of the recorded video indicated the resident was lying on his back in bed when the AP entered the resident's room. The AP began to assist the resident with cares and told the resident to turn to his left side. The resident attempted to roll to his left side when the AP grabbed the disposable bed pad and used the pad to aggressively force the resident over to his left side and into the wall. The resident appeared startled and reached his right hand out and grabbed the AP's hair. The AP let go of the resident and the resident rolled over onto his back. The AP yelled something unintelligible at the resident and hit the resident in the face. The AP backed away from the bed and yelled, "Why did you grab my hair?" The AP approached the bed again, and the resident put his right hand up in a defensive posture. The AP then hit the resident in the face a second time and yelled at the resident, "Why you pullin' my hair like you're stupid, though?" The AP again attempted to roll the resident onto his left side again and the resident shouted, "Leave me alone!" The AP yelled at the resident, "What is wrong with you?" The AP continued with the resident's cares and the video ended.

When interviewed, leadership staff stated the video of the incident showed the AP aggressively rolling the resident to his left side and shoving the resident up against the wall. The resident flung his right arm back and appeared to grab the AP's hair. The AP struggled to free himself and hit the resident twice in the face in the process. One staff member stated the AP hit the resident with a closed fist and contact between the AP's hand and the resident's face could be audibly heard on the video.

When interviewed, the resident's family member stated they had reviewed the video and saw the AP hit the resident in the face two times. The family member stated the resident did not specifically recall the incident, but the resident did say he thought someone walked in off the street last night and "slugged me good."

The AP did not respond to requests for interview.

Review of the AP's personnel file indicated the facility provided the AP with vulnerable adult training upon hire.

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.

Vulnerable Adult interviewed: No, unable d/t cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, did not respond to requests for interview.

Action taken by facility:
The AP no longer works for 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
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28204	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING	3610 MOUNT VERNON COURT WOODBURY, MN 55129

(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: #HL282047776C/#HL282044524M On June 13, 2023 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 9 residents receiving services under the provider ' s Assisted Living license. The following correction order is issued/orders are issued for #HL282047776C/#HL282044524M, tag identification 2360.	0 000	No plan of correction is required for this tag.	
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 covered under the Vulnerable Adults Act.	02360		

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HOMETOWN SENIOR LIVING - WEDGE	3610 MOUNT VERNON COURT WOODBURY, MN 55129

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident 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.	02360		