Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL299663682M
Compliance #: HL299666410C

Date Concluded: September 16, 2024

Name, Address, and County of Licensee Investigated:
Copperfield Hill
4020 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Inconclusive

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) abused a resident when the AP was found with the resident in her room and the resident had a bruise on her left eye and right arm. The resident reported the AP hit her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although the resident reported the AP hit her, nobody witnessed the AP hitting or harming the resident. The AP denied hitting the resident. It could not be determined how the resident got the bruises on her arm and under her eye.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, staff training, employee files, and facility policies and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with bathing, grooming, dressing, toileting, meals, and medication administration. The resident's assessment indicated the resident had difficulty communicating her needs and could be resistive to cares.

A facility investigation of the incident indicated the facility nurse was contacted by a unlicensed staff who reported they were in the hallway outside the residents room and heard the resident yelling. When the staff went into the resident's room the AP was trying to undress the resident. The staff noticed the resident had bruising under her right eye and a skin tear on her left arm. The resident stated the AP hurt her face and arm. The resident also told the staff the day before the AP threw her on the bed and was rough with her.

When interviewed the facility nurse stated the on-call nurse reported two unlicensed staff responded to the resident's apartment because they heard her yelling. The nurse stated the staff observed the resident with a mark on her face and a skin tear on her arm. The nurse stated the staff reported the AP was removing the resident's clothing. The nurse stated the AP was sent home pending investigation and the resident was interviewed. The resident told the nurse the AP was rough with her.

During interview, an unlicensed staff stated she saw the resident in the hallway yelling, "help me, help me, he hurt me." The staff stated the resident had a bruise on her eye and her arm, and the staff did not remember seeing those marks on the resident during dinner. The staff stated when she responded to the resident the AP was just walking out of the resident's room.

When interviewed the on-call facility nurse stated she received a call from the unlicensed personnel reporting the resident was yelling and she found the resident with a bruise on her eye. The on-call nurse stated she assessed the resident the next day and noted bruising on her eye and arm.

In an interview, the AP stated he noticed the resident had bruises earlier in the day and another staff member told him the resident had an altercation with another resident. The AP stated the resident had been combative during cares and was hitting out at him. The AP stated when the resident became combative, he left the room. The AP stated he did not hit the resident and he was not rough with the resident.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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;

Vulnerable Adult interviewed: No, due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility filed a report with the Minnesota Adult Abuse Reporting Center. The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
No action taken at this time.

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
	29966	A. BUILDING: _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERFIELD HILL THE LODGE	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

(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 July 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL299666410C/#HL299663682M. No correction orders are issued.	0 000		