Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL302467564M
Compliance Project: HL302463080C

Date Concluded: April 16, 2025

Name, Address, and County of Licensee Investigated:
Regina Assisted Living
1175 Nininger Rd
Hastings, MN 55033
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 the AP grabbed the resident's arm causing the resident to stumble and fall.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. After a physical altercation between the AP and the resident, the AP was witnessed pointing in the resident's face and stating she was going to call the police in a threatening manner.

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and a cognition communication deficit. The resident's service plan included assistance with bathing. The resident's assessment indicated the resident was unable to respond when staff knocked on door, staff were directed to knock, enter room and announce themselves. The same document indicated noise, or crowded areas trigger behaviors for the resident.

A facility report indicated the AP, an unlicensed caregiver, was involved in a physical altercation with the resident when the resident refused a scheduled task. The same report indicated the resident attempted to strike out at the AP, then the AP grabbed the resident's arms to prevent the resident from hitting her, causing bruising to left forearm.

During the investigation, an additional unlicensed caregiver was identified who did not witness the physical altercation but was approached by the resident immediately after in the hallway.

During an interview, the additional unlicensed caregiver stated the resident came down the hallway to him yelling for help and upset. While the caregiver tried to calm the resident, the AP approached, pointed her finger in the resident's face, and repeatedly said "I'm going to call the police on you" in a taunting manner. The caregiver stated the resident was getting further agitated and the AP was told to stop and leave. The unlicensed caregiver stated they kept a close watch over the resident until the end of the shift as they were worried about the resident's safety.

During an interview, the AP stated she felt another facility staff member had upset the resident, and when she attempted to provide the scheduled care, the resident struck out at her, she grabbed the resident's arms to protect herself from getting hit. The resident began backing up into his room when she was holding his arms, lost his balance and the AP stated she needed to "gently" lower him to the floor. The AP stated after this she assisted the resident up off the floor and transferred him to a chair. The AP stated after leaving the resident's room, the resident ran after her in the hallway and struck her in the abdomen. The AP stated she was only joking with the resident at the medication cart that she was going to call the police.

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 due to dementia
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The AP is no longer employed 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:
Office of Ombudsman for Long Term Care
Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Hastings City Attorney
Hastings 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
	30246	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA ASSISTED LIVING	1008 1ST STREET WEST HASTINGS, MN 55033

(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 1, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL302463080C/#HL302467564M. The following correction order is issued for #HL302463080C/#HL302467564M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State 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 USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. 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 person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		