# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306883422M
**Compliance #:** HL306883621C

**Date Concluded:** June 24, 2024

**Name, Address, and County of Licensee Investigated:**
Epiphany Assisted Living
10955 Hanson Blvd. NW
Coon Rapids, MN 55433
Anoka County

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

**Evaluator's Name:**
Jana Wegener, 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 resident was abused when the alleged perpetrator (AP), facility staff, was demanding and rough with the resident. The resident screamed, "Oww, she slapped me," and pleaded with staff not to leave her alone with the AP.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was inconclusive. The resident and AP were in the resident's room with the door closed. The resident stated the AP hit her, however, the AP denied hitting the resident. There were no witnesses to the incident and when the resident was assessed for injury's the following day none were noted. The resident was unable to recall the incident. It could not be determined if abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), facility internal investigation, facility

incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed the resident and staff in the facility.

The resident resided in an assisted living memory care unit with diagnoses including dementia, glaucoma, and was legally blind.

The resident's individual abuse prevention plan (IAPP) indicated the resident was cognitively impaired, and not able to report abuse. The IAPP instructed staff to monitor for possible signs and symptoms of abuse and follow the facilities abuse reporting process.

A facility investigation indicated one evening leadership nursing staff received a report staff heard the resident scream, "Ow, she slapped me!" The resident's door was closed, and staff entered the room to check on the resident. The witness noticed the AP in the room demanding the resident bend her knees to place them on the foot pedals. The AP stated, "We have to get ready to eat", and the resident responded, "Not with you!" then repeated the AP had slapped her. The facility investigation identified the resident would sometimes yell out and state something hurts during transfers or cares. The facility investigation indicated the following morning when the resident was assessed for injuries there was no redness or signs of abuse noted at that time. The investigation indicated the resident had no recollection of the incident.

Several staff stated the resident was a reliable reporter of abuse in the moment but due to cognitive impairment would not be able to recall the incident. Staff stated it was not unusual for the resident to yell out during cares and say staff were hurting her but indicated the resident had never made statements that staff had slapped her before.

When interviewed the staff witness stated she heard the resident yell out and a hand to skin slap sound loud enough she could hear it through a closed door. Then, she heard the resident say "Ow, you slapped me!" The witness stated when the door opened the AP was the only staff in the room with the resident. The witness indicated the AP appeared hurried, rushed, aggressive, and showed a lack of patience toward the resident which made the witness feel uncomfortable as the AP proceeded to get the resident ready to go to dinner. The witness stated the AP told the resident "We have to go to dinner", and the resident responded, "not with you!" then pleaded with the witness not to leave her alone with the AP. The witness stated the AP did not deny the resident's allegation of slapping the resident or try to redirect/comfort the resident. The witness indicated she did not look for or notice any signs of redness on the resident when the incident occurred.

Nursing leadership stated when interviewed the AP stated the resident always yelled out during cares. Leadership stated the AP's statement was concerning because the resident does not "always yell out during cares" and had never reported staff slapped her prior to the incident. Leadership stated when the resident was assessed for injuries and signs of abuse the following morning, none were noted, and the resident had no recollection of the incident.

When interviewed the AP denied the allegation. The AP stated it was not unusual for the resident to yell or say staff were hurting her while providing care. The AP stated when the witness entered the room to check on the resident the resident yelled out and accused that staff of hurting her also.

The resident's family member stated staff had not reported the resident had behaviors of yelling out during cares or saying staff were hurting her. The family member stated the resident had made no reports of abusive concerns, but indicated due to the resident's dementia she would not remember from day to day.

The AP's facility personnel records indicated she had no disciplinary action or patterns of abusive conduct concerns.

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

**Action taken by facility:**
The facility removed the AP from providing care to the resident and other residents in the facility. The facility investigated the incident and reported the concern to the Minnesota Adult Abuse Reporting Center (MAARC). The AP is no longer employed by the facility.

**Action taken by the Minnesota Department of Health:**
No further 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 |
|---|---|---|---|
| | 30688 | A. BUILDING: _____ B. WING _____ | C 05/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EPIPHANY ASSISTED LIVING LLC | 10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433 |

| (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<br><br>On May 22, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306883422M/#HL306883621C. No correction orders are issued. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |