



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315734585M
Compliance #: HL315737918C

Date Concluded: July 11, 2023

Name, Address, and County of Licensee

Investigated:

Willows of Ramsey Hill
80 North Mackubin Street
St. Paul, MN 55102
Ramsey County

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

Evaluator's Name: Willette Shafer, 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) abused a resident when the AP pushed the resident twice.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. A nurse observed the AP forcefully push the resident twice with arms extended causing the resident to stumble.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of resident records, personnel records, internal investigation, and facility policies. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and congestive heart failure. The resident's service plan included assistance with grooming, toileting, medication management, bathing, reminders, and safety checks. The resident's assessment indicated the resident had a history of wandering but was easily redirectable.

During an interview, a nurse stated she was in her assigned resident's room across the hall when she heard someone yell "get out of here." She walked to the door and saw the AP push the resident out of another resident's room he had wandered in, into the hallway. The nurse stated the resident stumbled forward when the AP pushed him. The nurse stated she saw the AP push the resident a second time while in the hallway and the resident stumbled forward again. The nurse stated the AP was unaware the nurse was watching her from a room across the hall. The nurse stated she has easily redirected the resident in the past when he wandered. The nurse stated the AP used excessive force against the resident and described the AP extending both arms forward to push the resident twice. The nurse reported the incident and requested the AP not be allowed to work with her resident out of concern with the AP's behavior.

During an interview, a family member stated the resident was easily redirectable when you offered him a piece of chocolate or a cup of coffee. The family member stated they recently brought in a bag of chocolate to assist with redirection.

During an interview, the AP stated the resident was in another resident's room when she redirected him by placing hands on. The AP stated she placed her arm under his arm, lifted him up, put her body close to his, and "motored" him out the door from side to side. The AP said she heard a nurse reported her for abuse but never saw the nurse during the incident.

During an interview, a member of management stated she completed the internal investigation, and the AP is no longer employed at the facility. The management member stated the nurse reported the AP pushed the resident with ill intent. The management member stated the AP completed all required training for Vulnerable Adult Maltreatment and dementia care.

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, due to cognitive deficit.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation and implemented interventions to prevent future incidents. The facility completed follow up education with all employees.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. 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>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31573	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/21/2023
NAME OF PROVIDER OR SUPPLIER WILLOWS OF RAMSEY HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102		
(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL315737918C/#HL315734585M</p> <p>On June 21, 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 56 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL315737918C/#HL315734585M, tag identification 0620, 2360 and 3000.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 620	<p>Continued From page 1</p> <p>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/ abuse for one of one resident (R1) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the facility on October 10, 2019. R1's diagnoses included Alzheimer's disease, and congestive heart failure.</p> <p>R1's undated internal investigation, indicated on January 20, 2023, at 6:20 p.m., registered nurse (RN)-B observed unlicensed personnel (ULP)-A push R1 twice. RN-B reported the incident to the licensed assisted living director the next day. A MAARC report was filed January 24, 2023.</p> <p>During an interview on June 21, 2023, at 10:20 a.m., director of health services (DHS)-C</p>	0 620			

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0 620	Continued From page 2 confirmed the facility failed to file a MAARC report within 24-hours of the incident. Licensee's, Vulnerable Adult Maltreatment, policy dated August 1, 2021, indicated when abuse or neglect was discovered, a MAARC report would be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620			
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. 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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury	03000			

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03000	<p>Continued From page 3</p> <p>which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event</p>	03000			

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03000	<p>Continued From page 4</p> <p>meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/ abuse for one of one resident (R1) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the facility on October 10, 2019. R1's diagnoses included Alzheimer's disease, and congestive heart failure.</p> <p>R1's undated internal investigation, indicated on January 20, 2023, at 6:20 p.m., registered nurse (RN)-B observed unlicensed personnel (ULP)-A push R1 twice. RN-B reported the incident to the licensed assisted living director the next day. A MAARC report was filed January 24, 2023.</p> <p>During an interview on June 21, 2023, at 10:20 a.m., director of health services (DHS)-C confirmed the facility failed to file a MAARC report</p>	03000			

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03000	<p>Continued From page 5</p> <p>within 24-hours of the incident.</p> <p>Licensee's, Vulnerable Adult Maltreatment, policy dated August 1, 2021, indicated when abuse or neglect was discovered, a MAARC report would be made no later than 24 hours after the maltreatment was first suspected.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	03000			