Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315861760M
Compliance #: HL315869526C

Date Concluded: July 31, 2024

Name, Address, and County of Licensee Investigated:
Bel Rae Senior Living
2330 Mounds View Boulevard
Mounds View, MN, 55112
Ramsey County

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

Evaluator's Name: Lissa Lin, 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 the resident when he wheeled the resident along a hallway too fast and crashed her into a wall. The resident was upset and cried but was not physically harmed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There was unclear and conflicting evidence to what occurred when the AP transported the resident. The staff member working with the AP provided a written statement but failed to interview with the investigator. The written statement failed to identify if the staff member witnessed the incident or only heard interactions and received report from another resident. Management staff indicated the AP's actions were inappropriate even if the resident was unharmed. The AP denied the allegations.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the AP and the resident's family member. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed staff and family transport the resident in her wheelchair. There was no video of the incident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, generalized anxiety disorder. The resident's service plan indicated she used a wheelchair and required assist of one staff for transfers with a gait belt if she used her wheeled walker. The resident required toileting assistance. She could make her needs known.

The AP's personnel file included an incident summary and staff statements. A written statement by a staff member who observed the incident, indicated the resident was sitting at the table and asked to use the bathroom. The AP took the resident, seated in her wheelchair, tipped the wheelchair back and was doing a "wheelie." The resident was screaming and crying scared. When the resident got to her room she was crying and screaming "my arms please your [sic] hurting me." "STOP" "please stop!" The AP then brought the resident back to the table. The resident was upset, crying at the table. The resident later asked again to use the bathroom. The AP took the resident and purposely ran her wheelchair into a wall. The resident started screaming "your [sic] hurting me please stop." Another memory care resident called to the staff member for help. The staff member went to the resident's room and the resident was "drenched" with bowel movement and urine running down her legs. The resident was "double padded" with two incontinent pads filled with urine. The staff member reported the incident to nursing.

It was unclear by the written statement what the staff member witnessed versus what she heard and had reported to her by the other resident.

The incident summary indicated a nurse and the director of nursing (DON) went looking for the AP after receiving the report, but the AP had left the building while on break and did not answer his phone. The nurses assessed the resident and attempted to interview her, but she was to too upset to talk and crying. The nurses interviewed the other resident who witnessed the incident. The other resident stated "he ran her into the wall on purpose" and she kept crying for help and to stop, but he would not.

The AP left before the end of his shift without management permission. The DON called the AP, asked him to return to the facility to discuss the incident and the AP refused. The DON informed the AP he was suspended pending an investigation. Management contacted the AP for a written statement. The AP refused to interview nor provided a written statement. The AP sent management a text message denying the false accusation of harming the resident, but it did not include a description of the incident. A few days later the AP resigned from his position without providing a statement on the incident.

The resident provided a brief statement to the nurse indicating she screamed and the AP told her to stop screaming. However, the resident was unable to state what happened.

During an onsite visit, management staff was unclear where in the hallway the incident took place. The investigator did not observe any damage or repair evidence to the wall.

During an interview, a manager said the resident could be dramatic. The AP told her on a phone call that he was having fun with the resident. He had no previous complaints about transporting residents.

During an interview, the DON said the AP's action was not ok even if the resident was not hurt. She said the resident could not articulate what happened very well.

During an interview, the AP said he worked at the facility several months. He worked all over the building and often did double shifts. That day, around one o'clock he took the resident to the bathroom, then went on his break and left the building. The AP said he did not recall running her into a wall while taking her to the bathroom. About an hour after his shift ended, the AP said he got a call from a nurse at the facility, who said the resident complained to a family member about her cares, that a staff person "beat on her." They asked him to come in the next day to give a statement and he agreed. The AP said he had no idea what was going on and would never run a resident into a wall or beat them. The AP said the resident was a nice person, but she yelled for help all the time when staff transported her in her wheelchair. Everyone knew that. The AP said if he bumped the resident during cares he apologized. He said it was shocking when he heard the abuse complaint. He went to the facility the next day to give a statement and sign paperwork, but no one met with him, so he returned his key fob and left. He said he could not work there any longer.

During an interview, the resident's family member said the nurse told her about the incident. The family member said she was happy with the cares at the facility and had no concerns. The resident never mentioned the incident and the family member did not think abuse occurred.

Records reviewed indicated the AP completed and passed computer trainings on dementia, person-centered cares, fraud and abuse.

In conclusion, the Minnesota Department of Health determined abuse 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:

(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. Statement collected by nurse after incident.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and assessed the resident. The AP no longer works at the facility.

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.

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
	31586	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL RAE SENIOR LIVING	2330 MOUNDS VIEW BOULEVARD MOUNDS VIEW, MN 55112

(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****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #HL315869526C/#HL315861760M On June 25, 2024, 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 51 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL315869526C/#HL315861760M, tag identification 0460, 2460.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to provide a means for independent living (IL) residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the ability to impact all independent living residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 460		

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0 460	Continued From page 2 The findings include: During the entrance conference June 25, 2024 at 9:25 a.m., executive director (ED)-A said all residents have emergency call pendants, except the independent living (IL) residents. They received one daily safety check. R4 lived in an independent living apartment. R4's Assisted Living Contract dated August 1, 2021, indicated R4 paid monthly rent and a second occupant fee. Section 7 of Terms and Conditions indicated services available through provider; fees, all housing and services and amenities included in the monthly rent are identified on Attachment A to this agreement. Attachment A: Housing Services Included in Rent The following housing services and amenities are included in the rent portion of the monthly fees: -Designated unfurnished apartment with window blinds -Private bathroom -Keys/fobs to apartment, building and mailbox -Emergency call system hardware (hardware only, add'l charge for provider response) -Telephone jacks -Individually controlled heating and air conditioning Attachment A: Access to Common Areas and Amenities: -Staff available 24 hours per day/ days per week Attachment B: Housing Services for an Additional Fee The following services and amenities are provided the community upon request. These services and amenities are not included in the monthly fee rate but are available for an	0 460		

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0 460	Continued From page 3 additional charge: -Resident meals -Guest meals -Meal Delivery -Guest Suite -Housekeeping and laundry not included in rent -Furniture and carpet cleaning services -Deep cleaning services -Additional maintenance services -Handyman services -Activities when a fee is necessary -Additional keys -Pet fee -Postage stamps -Reserved parking in attached garage with garage door opener -Storage locker -Second occupant fee -Moving fee/internal apartment transfer fee -Replacement: keys, fobs, door locks, emergency call pendant R4's Vulnerability Assessment dated February 12, 2024, indicated he had no areas of vulnerability needing interventions. During an interview on June 25, 2024, at 1:55 p.m., unlicensed personnel (ULP)-H said she was not sure if any independent living residents had emergency call pendants. They had to call 911. During an interview on June 25, 2024, at 2:00 p.m., R4 said he had lived at the licensee for about 3 years and never had an emergency call pendant. R4 said none of the independent living residents had emergency call pendants. If they needed help they called 911. An email reply from ED-A dated July 3, 2024, at 3:03 p.m., indicated independent living residents	0 460		

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0 460	Continued From page 4 could request a basic assisted living service package if they wanted an emergency call pendant. Currently there were no independent living residents with emergency call pendants. In the event an independent living resident fell or needed assistance, staff would call 911. The licensee's marketing packet included an Independent Living 2024 price sheet. A daily "I'm ok" check was included in the monthly rent. Hospitality Pricing listed services and amenities not include in the monthly rent did not list emergency call pendants as an additional service. A policy titled 24-Hour Emergency Response, indicated residents living at Bel Rae Senior Living have access to 24-hour emergency response by staff. All residents are given instructions on the use of the emergency response system upon move in and ongoing as needed. The emergency system is to be used for any emergency need. Minnesota Statute 144G.08, Subd. 59. Resident, defined "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. Time Period to Correct: Seven (7) Days	0 460		
02460 SS=D	144G.91 Subd. 18 Right to access food Residents have the right to access food at any time. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. This MN Requirement is not met as evidenced	02460		

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02460	Continued From page 5 by: Based on record review, observation and interview, the licensee failed ensure staff members provided access to meal alternatives and requested food for one of one resident (R3) reviewed. R3 verbalized she did not like the noon meal because she did not like cheese and unlicensed personnel (ULP)-E and ULP-F failed to offer R3 alternative meal choices. R3 asked for a banana instead and ULP-F told her the kitchen was out of bananas without checking. 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). The findings include: R3 lived in one of the building's two memory care units. R3's diagnoses included Alzheimer's disease and diabetes. R3's service plan agreement dated June 15, 2024, indicated R3 received cueing assistance with activities of daily living (ADLs), medication management and mealtime reminders. R3's level of care assessment dated June 14, 2024, indicated she had a regular diet and liked chocolate and honey nut Cheerios. On June 25, 2024, at 11:45 a.m., the MDH surveyor observed the noon meal in progress in the "Swing" memory care unit. Five residents were eating lunch in the dining area. Two staff	02460		

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02460	Continued From page 6 members, ULP-E and ULP-F, stood nearby in the kitchen area. R3 asked "Is this cheese? I don't like cheese." ULP-F said "It is rice. If you don't want it you can leave it on the plate." R3 asked a second time if there was cheese in her food. During the observation, ULP-E said he was not sure if there was an alternative meal for residents, he would check. ULP-E then walked around the dining area and talked to some of the residents. ULP-F said if someone didn't like the meal they could have more salad. ULP-F did not offer R3 more salad. On June 25, 2024 at 12: p.m., during an interview in the dining area, R3 said she was "Ok until I sat down to eat. The rice tastes too much like cheese." There was one enchilada with cheese topping, a scoop of rice and salad on her plate. About 2/3 of the enchilada was left on the plate along with the rice and salad. R3 had a small bowl with a few cracker-type snacks she ate and asked for a banana again. ULP-F said the kitchen was out of bananas and she could have an orange or an apple instead. Neither ULP-E or ULP-F called or went to the main kitchen to check if there were bananas. During an interview at 12:05 p.m., culinary server (S)-G checked with the main kitchen and said they had bananas. S-G said staff can call or walk up to the main kitchen and request meal substitutes or special items. S-G said sometimes the memory care units can be out of an item but it does not mean the kitchen does not have the item. S-G said he was not aware of anyone in memory care asking for a banana. During an interview on June 25, 2024 at 1:15 p.m., executive director (ED)-A said they have "always available" meal alternatives but the are	02460		

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02460	Continued From page 7 not on the menu. ED-A said residents can ask for them or staff can offer them. If a memory care resident specifically asks for a specific food item, staff should see if it is available and get it for the resident. The menu for June 23 through June 29, 2024 only listed lunch and dinner meals. A policy titled Food Service and Menu Planning, dated July 25, 2021, indicated meal substitutions will be of similar nutritional value if a resident refuses a food that is served. Residents have the right to access food at any time, the facility will not restrict access to food unless certain circumstances are necessary for the resident's health and safety and documented in the resident's record. TIME PERIOD TO CORRECT: Seven (7) Days	02460		