

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318563561M
Compliance #: HL318563960C

Date Concluded: August 13, 2024

Name, Address, and County of Licensee

Investigated:

Minnetonka Care Residence
421 Spring Valley Drive
Bloomington, MN 55420
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Maerin Renee, 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 the AP shoved the resident into a closet door.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. The resident stated the AP pushed her into her closet door. The AP denied pushing the resident and said the resident fell when she tripped on her own shoes. The resident and AP were alone in the resident's room and there were no witnesses to 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 also contacted law enforcement. The investigation included review of the resident records, facility incident reports, personnel files,

staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease. The resident's services included assistance with dressing, grooming, toileting, transfers, meals, and medication management. The resident's assessment indicated the resident was easily agitated and staff were instructed to redirect the resident with conversation and reassurance.

An incident report indicated the AP helped the resident use the commode in her room. At one point, the resident spit on the AP and told the AP she hated her. The AP reported the resident placed her hands around her neck. The AP said she removed the resident's hands and told her to stop. The AP stated the resident asked her what she was going to do about it and suddenly reversed back, throwing herself into the closet. The AP left the resident's room and reported the incident to leadership. After the police arrived, the resident said she wanted to press charges against the AP. The police officer said he would need to press charges against both the AP and the resident for fifth-degree misdemeanor assault. The police did not make any arrests but collected statements from the AP and the resident.

The resident's progress notes indicated a supervisor received a call from the AP. The AP said she helped the resident use the commode in her room. The resident yelled at the AP and said she hated the AP. The AP asked the resident to move so she could leave the room, but the resident would not let the AP exit the room. The resident continued to yell at the AP, moved closer to the AP, and put her hands around the AP's neck. The AP said the resident tried to choke her, and when the AP pushed the resident's hands off her neck, the resident stumbled back into the closet door. The AP left the room. Another staff member checked on the resident, but the resident locked her door and would not let the staff member in. The resident told the staff member the AP pushed her down and she wanted to press charges. The resident called the police.

The police report indicated the resident asked the AP to help her with toileting. The resident asked the AP what was for dinner, and the AP appeared upset. The resident said the AP threw her across the room, shoving her into the bedroom closet door. The resident declined an ambulance, and police documented there were no signs of injury. The AP reported she helped the resident with toileting. The resident then began to yell at the AP. The resident told the AP she hated her, and spit in the AP's face. The AP said the resident grabbed her neck and tried to choke her. The AP left the room, and the resident called police. The AP said the resident had never been aggressive with her before.

When interviewed, the AP said she helped the resident use the commode in her room, and the resident became agitated and angry. The resident spit on her said she hated her. The resident put her hands on the AP's neck and attempted to choke her. The AP was startled, as she believed she had a good relationship with the resident. The AP feared for her safety and

brushed the resident's hands away, asking the resident to take her hands off her. The resident blocked the door, so the AP was unable to leave the room. The AP attempted to leave the room and said the resident approached her again. As the AP passed the resident, the AP said the resident tripped on her own shoes, which were ill-fitting, and fell back into the closet door.

When interviewed, the resident said the AP was helping her use the commode. The resident said she put her arms out for the AP to guide her back to the bed, and the AP shoved her backwards. The resident said she fell and hit her head on the closet door. The resident did not know why the AP shoved her, as they generally got along very well.

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 notified the resident's family and case manager. The resident was assessed for injuries.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31856	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER MINNETONKA CARE RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 421 SPRING VALLEY DRIVE BLOOMINGTON, MN 55420
--	---

(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>On July 9, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL318563960C/#HL318563561M. No correction orders are issued.</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>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____