Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329134241M
Compliance #: HL329135126C

Date Concluded: October 11, 2024

Name, Address, and County of Licensee Investigated:
Inspired Senior Living of Hanover (Volante of Hanover)
10875 Settlers Lane
Hanover, MN 55341
Hennepin County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility and 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):
An alleged perpetrator (AP#1), a facility staff member, neglected a resident when they failed to follow the resident's plan of care based upon the resident's assessed needs for transfer assistance.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. During the investigation, the investigator determined AP #1 and AP#2 were responsible for neglect. Instead of using extensive assistance of two staff and a gait belt to transfer the resident, AP#1 and AP#2 were seen in separate video footage inappropriately transferring the resident alone, using only one hand or having the resident transfer herself causing the resident pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's family member and former employees. The investigator interviewed AP#1 and AP#2. The investigation included

review of the resident record, facility internal investigation, recorded video footage, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed direct staff cares during her onsite investigation.

The resident resided in an assisted living facility with dementia care and received hospice care at the facility. The resident's diagnoses included dementia, multiple rib fractures on her right side, and arthritis in both shoulders. The resident's required frequent, hands-on extensive assistance with transfers from two staff persons using a gait belt. The resident required great care when transferred due to painful arthritis in both shoulders and body.

Recorded video and audio footage cameras (Blink) placed in the resident's room by family members captured multiple video clips showing AP#1 and AP#2 stand-by and watch the resident struggle as she attempted to transfer herself to bed or into the wheelchair.

In a recorded video, the resident moved in her wheelchair pointing and mumbling about the bathroom when AP#1 pushed the resident into the wheelchair using the resident's left forearm. The video footage lacked evidence AP #1 had a second staff and a gait belt to assist with the resident's transfer and toileting.

In another recording, the resident sat in her wheelchair positioned close to her bed as AP#1 stood behind the wheelchair holding onto the wheelchair handles. AP#1 watched the resident struggle to transfer herself to bed. Suddenly, AP#1 shoved the resident onto her bed, causing the resident to scream in pain as she landed on both shoulders then ended up lying on her right side and arm. AP#1 was heard telling the resident, "Don't lay on that arm!" AP #1 transferred the resident without a gait belt and second staff.

In several video recordings, AP#2 was seen transferring the resident by grabbing the resident's upper arm under the armpit as AP#2 lifted and dropped the resident with one hand onto her wheelchair causing the resident to scream in pain. On each recording, AP#2 transferred the resident without a gait belt and a second staff.

Review of AP#1 and AP#2's personnel files indicated both received vulnerable adult and transfer training.

During an interview, AP#1 stated she "barely" received any training when she started working at the facility, stating another staff person was supposed to train her during her first shift but instead she worked the entire floor by herself that night. AP#1 stated the resident was a two-person transfer depending on the day, stating the resident was dead weight and it was easier to let the resident transfer herself rather than receive assistance from staff.

During an interview, AP#2 stated he never received transfer training when he was first hired. AP#2 stated he was taught to put his hand underneath the resident's armpit during transfers, stating AP#1 transferred the resident the same way as he did.

During an interview, a former facility nurse stated she was disheartened and upset when she reviewed the recording showing AP#1 not assisting the resident into bed. The former facility nurse stated she was pretty sure AP#1 was allowed to return to work with no repercussions, stating she felt AP#1's actions were intentional and malicious.

During an interview, the resident's family member stated facility staff knew not to grab the resident's shoulders or arms because of the resident's constant pain in that area.

In conclusion, the Minnesota Department of Health determined neglect and abuse were 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Unable due to her level of cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes. AP#1 and AP#2 were interviewed.

Action taken by facility:
The facility conducted an internal investigation and required additional training for AP#1 and AP#2.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible parties 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
Hennepin County Attorney
Hanover City Attorney
Hanover Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32913	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLANTE OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL329135126C/#HL329134241M On July 31, 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 19 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL329135126C/#HL329134241M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED SENIOR LIVING OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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02360	Continued From page 1	02360		
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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		