Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL332604123M
Compliance #: HL332606936C

Date Concluded: April 3, 2023

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Vadnais Heights
580 Liberty Way
Vadnais Heights, MN 55127
Ramsey County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 restrained the resident while assisting the resident with toileting, which resulted in multiple bruises and a laceration on the resident's hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. A witness saw the AP grab the resident's arms and prevent the resident from moving her arms, which caused bruises and a skin tear.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and viewed photos of the resident's injuries. The investigation included review of incident reports, resident medical records, policies and procedures related to incident reporting, contacting the nurse, service plan implementation, orientation/training of unlicensed personnel, and maltreatment of

vulnerable adults. The investigator reviewed the AP's personnel file, including training received, job description, and performance concerns. In addition, the investigator observed resident/staff interactions in the memory care unit.

The resident lived in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with fall prevention, safety checks every two hours, dressing/undressing, toileting every two hours, transfers with one staff with a gait belt, incontinence cares, skin care, and behavioral support.

The resident's care plan dated two months prior to the incident indicated if the resident had behaviors (identified as anxiety, agitation, and refusal of cares) staff were to use the following interventions: Soft/calm approach, soft/soothing voice, make eye contact, re-approach, assist the resident to the room to calm, and offer distractions.

An incident report indicated one Sunday the resident struck out and hit the AP while toileting. The report indicated the AP called for another staff to assist, and both staff received scratches on their hands. The AP reported to the on-call nurse the resident received no injuries.

A progress note written on the following Monday indicated the resident had a bruise on the top of her right hand between her thumb and finger (measured 5 centimeters (cm) x 6 cm), and a bruise on the top of her left hand between her thumb and finger (measured 3.2 cm x 3 cm) with a skin tear (measured 1 cm x 1 cm). The note indicated the resident complained of pain.

During an interview an administrative staff stated the resident had increasing behaviors due to her diagnoses. The administrative staff stated the resident's care plan had not been updated with new interventions/approaches.

During an interview, another administrative staff stated the care plan directed staff to leave the resident if striking out, but she also stated she would not want staff to leave the resident on the toilet alone. The administrative staff stated she did not know what interventions the AP had tried, if any.

During interviews several staff gave detailed description of interventions they had learned from working with the resident, such as swapping out staff, avoiding approaching the resident with two staff at once, easing into interacting with the resident, changing the topic, providing the resident with entertaining information, etc., but stated none of the approaches or techniques were documented.

During an interview, a witness stated the AP asked for help changing the resident. The witness stated she was new at the job and the AP directed her to quickly change the resident's pants while the AP changed the resident's shirt. The witness stated they both did this at the same time and the resident struck out at them. The witness stated the AP, who was on the resident's

left side, grabbed the resident's arms to stop her from hitting. The witness stated she did not know the resident received bruises or a skin tear.

During investigative interviews, multiple staff members stated they observed the AP being verbally aggressive and rough with residents.

During an interview, a family member stated the facility initially told him the resident had no injuries from the incident. When the family member visited the resident the next day, he was appalled to see the bruising and skin tear. The family member stated there was blood all over the resident's bed from the skin tear.

The AP did not respond to requests for an interview or to a subpoena.

In conclusion, 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:
(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;

Vulnerable Adult interviewed: Yes, limited due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, did not respond to request or subpoena

Action taken by facility:
The facility began documentation of the resident's behaviors.
The AP no longer works for 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

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
Vadnais Heights City Attorney
Vadnais Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33260	A. BUILDING: _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF VA	580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127

(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 LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL332606936C/#HL332604123M On March 8, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 26 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL332606936C/#HL332604123M, tag identification 2310 and 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 1 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure staff provided appropriate care and services individualized to the resident, related to behaviors for one of one resident (R1) reviewed for maltreatment. Unlicensed personnel (ULP)-H grabbed R1's arms while toileting the resident and R1 was striking out. R1 received bruises and a skin tear. In another incident, ULP-I left R1 sleeping on the floor on a fall mat for four hours after R1 got out of bed. The licensee failed to implement an up-to-date service plan with individualized interventions subject to accepted health care standards. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). Findings include: R1 admitted to the memory care unit of the facility on January 23, 2019, due to diagnoses that included Alzheimer's disease. R1's Service Plan revised January 20, 2022, indicated R1 required assistance of one staff for	02310	Minnesota Department of Health is documenting the State Licensing 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	

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02310	Continued From page 2 toileting. The service plan included fall interventions to include placement of fall mats on the floor next to both sides of R1's bed. The service plan indicated R1 required one staff assist to the toilet, and staff check and change every two hours. The service plan indicated the resident required transfer assistance of one staff with a gait belt and if R1 felt weak/unsteady, to use two staff and a gait belt. The service plan indicated R1 demonstrated inappropriate judgment related to safety by crawling out of bed and from the broda chair onto the floor. The service plan directed staff to complete safety checks every two hours. R1's service plan directed staff in the event of "behaviors", such as refusal of cares, to leave R1 safely and have another staff reapproach R1 after 10-20 minutes. The service plan directed staff to approach R1 in a calm, soft voice, tell R1 who they were, and what they were there for, offer their hand, offer distractions, talk with R1 about lunch/music/and the kitty on R1's bed. R1's service plan indicated R1 "exhibits inappropriate behavior: showing anger, provocation, verbal abuse, and other extreme and erratic behavior patterns". R1's Care Plan dated September 8, 2022, indicated R1 experienced orientation issues, aggression, anxiety, agitation, and refused cares. The Care Plan directed staff to use the following interventions, "soft/calm approach, soft/soothing voice, make eye contact, re-approach, re-orient PRN (as needed), assist R1 to room to calm, and offer distraction". R1's Incident Report dated November 27, 2022, at 10:15 a.m. indicated ULP-H took R1 to the	02310	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02310	Continued From page 3 bathroom and R1 "was being abusive-hitting, punching, and scratching". The incident report did not include information about interventions, if any, were attempted. The registered nurse (RN) review section of the incident report signed by licensed practical nurse (LPN)-A indicated "LPN-A informed POA [power of attorney]". There was no documentation of an investigation. R1's progress note dated November 27, 2022, at 10:30 a.m. (identified as a "late entry") indicated staff informed RN-F that R1 was hitting staff during cares. RN-F documented staff told her R1 "had no marks, discoloration, or open areas on her skin". R1's progress note dated November 28, 2022, at 2:21 p.m. indicated R1 had a bruise (5 centimeters (cm) by 6 cm) on the top of her right hand near her thumb and index finger. The progress note indicated R1 stated she felt "light pain". The note indicated R1 also had bruising on the top of her left hand near her thumb and index finger (3.2 cm by 3 cm) and a skin tear 1 cm by 1 cm and 0.2 cm deep. The progress note indicated LPN-A cleansed, dried, applied antibiotic lotion, and covered the area with a band-aid. R1's Fall Scene Investigation Report dated January 10, 2023, at 1:00 a.m. indicated R1 "used the side rail to place herself on the fall mat nearest the window". The report indicated staff (ULP-I) "tried to get her [R1] up off the floor, but resident [R1] refused and ended up sleeping on the mat". The report indicated on-coming staff found R1 at 5:00 a.m. sleeping on the mat with a pillow and blanket. R1's completed tasks document for January 9, 2023, night shift into January 10, 2023, indicated	02310		

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02310	Continued From page 4 no documented completion of the following services: "check and change resident every two hours", "Assistive device: needs gait belt for all transfers with one staff assistance". R1's record contained no indication staff checked on R1 (during the night shift from January 9, 2023, to January 10, 2023) while she lay on the floor. The facility Nurse -Caregiver Communication book contained no information about behaviors or interventions specific to R1 prior to the November 27, 2022 incident. A page dated November 29, 2022, indicated due to an increase in aggressive behaviors from R1, staff were to document every time R1 had a behavior, becomes aggressive (verbally or physically), or becomes agitated. During an interview on March 8, 2023, at 11:57 a.m. LPN-A stated an approach that worked with R1, was to swap out staff and let someone else approach her when she refused cares. LPN-A stated he did not know if that was written anywhere for staff. LPN-A stated he had the staff involved write a statement describing their injuries after the November 27, 2023, incident. LPN-A stated he did not know if any changes were made to R1's care plan after either incident. During an interview on March 8, 2023, at 12:36 p.m. ULP-B stated when staff approached R1 with two staff at a time, R1 felt bombarded. ULP-B stated R1 did not do well when staff told her what to do, but if asked, she was more cooperative. ULP-B stated new staff were not trained to ease into interacting with R1, which worked better than just coming in and saying, 'we have to take you to the bathroom'. ULP-B stated none of the techniques were written down for staff	02310		

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02310	Continued From page 5 like talking about things she likes, taking their time with R1, etc. During an interview on March 8, 2023, at 1:00 p.m. ULP-C stated R1's level of cooperation depended on how staff approached her, like changing topics (weather, food, etc.) and providing entertaining information. ULP-C stated she listened to other caregivers and figured out approaches on her own because there is no direction in the care plan book specific to R1. During an interview on March 8, 2023, at 1:17 p.m. regional director of operations (RDO)-D stated it had become common for R1 to scratch and hit at staff during cares, so they started a behavior log. RDO-D stated the purpose of the log was to detail the facts of a situation during behaviors to look for patterns. RDO-D stated the nurse reviewed the behavior log but did not know what became of the information. During an interview on March 17, 2023, at 10:23 a.m. regional director of nursing (RDN)-F stated she did not participate in an investigation of R1's incident on November 27, 2023. She stated LPN-A completed an investigation.(The facility did not provide evidence of an investigation.) RDN-F stated she heard the incident occurred while R1 was on the toilet and RDN-F "would not want staff to move away from" R1 if that was the case. RDN-F stated she was on call the night of R1's slide to the floor (January 10, 2023, incident). RDN-F stated "staff are directed to leave [R1] and re-approach". RDN-F stated R1 had a pillow and blanket while sleeping on the floor, so was fine. RDN-F stated the purpose of behavior documentation was to look at things like time of day, and if the behavior is "sundowners". RDN-F stated, "some new approaches get implemented	02310		

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02310	Continued From page 6 sometimes", but the behavior documentation did not lead to any changes in interventions or approaches. RDN-F stated no changes were made to R1's service plan. RDN-F stated she did not know what interventions the staff used in either incident with R1. During an interview on March 20, 2023, at 4:30 p.m. ULP-G stated ULP-H yelled for her to come to R1's room on the day of the November 27, 2023, incident. ULP-G stated when she entered R1's room, ULP-H told her to just get down in front of R1 and quickly change R1's brief and pants while ULP-G changed R1's shirt. ULP-G stated R1 was agitated and hitting out, and ULP-G saw ULP-H grab R1's arms. ULP-G stated she did not recall using any special approaches with R1 and did not know that R1 was injured. During an interview on March 23, 2023, at 12:29 p.m. ULP-I stated she worked with R1 on the night shift on January 10, 2023, when R1 had "an incident". ULP-I stated she observed R1 sliding down from her bed, so ULP-I assisted her to the floor. ULP-I stated she then "lifted her [R1] up by the armpits and placed her back into bed". ULP-I stated she later observed R1 moving down from her bed again, and again assisted R1 to the floor. ULP-I stated she "did not want to keep lifting [R1] up onto her bed", so she "left her on the floor on the fall mats" and gave her a pillow and blanket. ULP-I stated there was another staff on the assisted living side of the building if ULP-I needed assistance. R1 stated if there was information about how to assist R1 it would be in the "book" (resident care plans) which told about all residents. ULP-I stated she did not recall using any type of approach with R1. ULP-I stated she reported to LPN-A in the morning after her shift about R1 sleeping on the floor.	02310		

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02310	Continued From page 7 During an interview on March 23, 2023, at 12:54 p.m. LPN-A stated he received a verbal report from ULP-I about the January 10, 2023, incident with R1. LPN-A stated ULP-I was not a regular employee of that location but picked up a night shift. LPN-A stated all employees were directed to review the book of resident care plans prior to working their shift, and the communication book, so they knew how to care for the residents. The Service Plan policy dated August 1, 2022, indicated the facility will implement and provide all services indicated in the service plan. The Service plan Modification policy dated July 20, 2021, indicated if a resident's service plan needed to be modified due to a change in resident needs, a new plan would include described changes in services. The Orientation and Training policy dated July 20, 2021, indicated staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
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:	02360		

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02360	Continued From page 8 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 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.	