Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339549682M
Compliance #: HL339549061C

Date Concluded: April 21, 2025

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of LI
197 County Road B2
Roseville, MN, 55113
Ramsey County

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

Evaluator's Name: Angela Vatalaro, 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), facility unlicensed personnel, physically abused the resident when the AP pushed the resident back into his wheelchair and when the resident attempted to stand, restrained the resident on the floor. The AP also emotionally abused the resident when the AP threatened the resident to call the police due to the resident's behaviors.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined physical and emotional abuse was substantiated. The AP was for the responsible for the maltreatment. The AP physically abused the resident when he forced the resident back down into his wheelchair when the resident attempted to stand. Also, when the resident stood up and walked, the AP pulled the resident backwards, took the resident to the floor, and using his hands held the resident down on the floor. The AP emotionally abused the resident when the AP made repeated threatening comments towards the resident that the AP was going to call the police, and the police were

going to “haul” the resident off and suggested to other staff to “call the cops” while the resident was on the floor.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigation included review of the resident’s records, facility incident reports, a personnel file, recorded video footage, and related facility policy and procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident’s diagnoses included encephalopathy (disease of brain), Parkinson’s disease with Lewy body dementia, and anxiety. The resident’s service plan included assistance with meal attendance and behavior monitoring. The resident had a history of punching staff, pulling staff hair, grabbing staff clothing, flipping over tables, moving furniture and appliances, required assistance with dressing, was independent with use of his wheelchair, and required staff encouragement to use the wheelchair. The service plan indicated the resident was not oriented, had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident’s assessment indicated the resident required one staff stand by assist for mobility and was a high fall risk. The resident required staff assistance with redirection and orientation.

The resident record indicated the resident admitted to the facility as a new admission at 10:30 a.m. the day of the incident. The resident’s weight was 191 pounds.

A progress note indicated at 4:28 p.m. the resident was agitated, and frequently tried to stand up from his wheelchair. The resident yelled at staff and attempted to hit staff; staff were unable to redirect resident. Staff gave the resident an as needed medication to calm the resident.

Review of a one minute and 45 second recorded audio and video footage located from above the common dining room and angled toward the resident’s dining table indicated at 4:47 p.m., the resident was seated in a wheelchair at a dining room table. No other staff except the AP was present in the dining room. The AP told the resident he had to stay in the chair and stated the resident had the right to do what he wants “like get up” and said, “like to get up and fall on the floor,” and told the resident he had the right to go the hospital, and that would cause the resident more problems. At that time, the resident attempted to stand up, the AP walked over to the resident and facing the resident, used his left hand and forced the resident back down by his front left shoulder, forcing the resident to a sitting position into the wheelchair. The wheelchair moved backwards from the actions. The AP, in an intimidating manner, stood over and in front of the resident who was seated in the wheelchair and said “go ahead” “you can do what you want to do,” and told the resident all that would happen is they would call the police, the police would haul the resident off somewhere, made a comment about the resident’s behaviors, and told the resident if he did not understand, the AP would make a phone call. At that time, two additional staff members arrived from a hallway pushing another resident into the dining room. Upon arrival, as the resident again attempted to stand, another staff asked the

resident if he wanted to eat, and the resident sat down on his own. The AP stood in front of the resident's wheelchair and backed away. The AP told the other staff members the resident would be alright, and the other two staff members continued to bring a different resident into the dining area. The resident voiced words that were inaudible. At that time, the AP went behind the resident and held the resident's left shoulder and the wheelchair handle preventing the resident from moving in the wheelchair and then let go. The recording ended.

The second recording lasting two minutes and five seconds at 4:59 p.m. showed fourteen other residents in the dining room along with the resident, the AP, and three other staff members. The other staff members were interacting and providing meals to other residents. With the AP watching, and with the wheelchair pedal down, the resident used the armrests from the wheelchair to go from a sitting to standing position having to step over the foot pedal. The AP failed to provide the resident assistance asked the resident "are you going to play games or are you going to listen." The AP walked over to the resident without assisting the resident and in a badgering way repeatedly said to the resident, "go ahead" "I'm not going to catch you, you can do what you want to do" as the resident stood up. The resident began to walk forward away from the AP. The complete view of the camera was obstructed by a pillar in the dining room limiting the view of the resident and AP, however, during that time, a staff member was heard saying "Oh, Oh, Oh, he's going to fall." The resident was on the left side of the pillar standing and walking forward. The AP did not attempt to retrieve or assist the resident into the wheelchair as the resident walked forward away from the AP. From behind the resident, the AP grabbed the resident's upper arm, held it, and pulled the resident backwards. The resident attempted to hold onto the nearby dining table causing the table to move as the resident was pulled backwards by the AP. Another staff member could be heard saying "Oh my Gosh." Although the camera's view was partially obstructed, the view showed the resident now on the floor laying on his right side with the AP bent over holding the resident down on the floor with his hand. During the incident, the resident did not resist the AP's actions. A staff member walked over to the area and asked the AP what he was doing, the AP said, "I am holding him down," the staff member asked "why?" At that point the AP using force, threw the resident's wheelchair about five feet into the hallway causing the wheelchair to collapse, almost hitting a staff member. The voices amongst staff became elevated and inaudible as to what was being said between all the staff, but the AP stated, "I'm not going to hurt myself, got to intervene." The AP with a raised voice directed toward the other staff repeated at least four times, "Do you want to call the cops…what do you want to do?" The staff directed the AP away from the resident, reassured the resident, and assisted the resident off the floor into his wheelchair. The recorded video ended.

During an interview, the AP stated he was assigned to work one to one with the resident that evening. The resident was a new admit, had behaviors, was physical towards staff, and would not stay in his wheelchair. The AP stated the resident was agitated. The AP stated he had to restrain the resident to protect himself (the AP) and other people. The AP stated he (the AP) was getting "sore" and "kind of injured" from holding the resident down and from restraining the resident. The AP stated during the evening meal, when the resident stood up to walk, the

AP pulled the resident backwards, brought the resident to the floor, and put his knee to the resident's back and held him down. The AP stated bringing the resident to the floor was the best decision to control the situation. The AP stated the resident needed staff with him to walk, could not walk alone, or could not walk two feet without losing balance. The AP stated he was trying to preserve his (the AP's) own personal safety, the resident's safety, other people's safety. The AP denied pushing or forcing the resident into his wheelchair. The AP stated he told the resident he may have to call the police on the resident. The AP stated even though the resident had dementia, the resident may still be aware enough to know that if he did not listen to the AP, calm down, the police may be called. The AP said he told the resident he would not catch him if he fell because it got to that point after an hour of the AP dealing with the resident's behaviors and the resident was not understanding what was going on.

During an interview, unlicensed personnel stated the AP was providing one to one care with the resident in dining room. She did not witness how the resident ended up on the floor because she was assisting other residents. The AP was agitated. The AP did not assist the resident off the floor. Other staff assisted the resident up. The resident did not say he was in pain, and said he was "okay." Prior to the resident moving in, leadership informed staff what kind of care the resident may need and talked staff about the resident's behaviors. They were trained to gently talk to the resident, not to make the resident sit down, suggest to the resident to sit down, and to provide the resident redirection. The facility provided monthly on-going staff education on ways to redirect residents.

During an interview, leadership stated she viewed camera footage. The AP appeared "very frustrated" with the resident.

During an interview, a nurse stated she reviewed camera footage because the other staff in the dining room requested to see the footage due to the incident that occurred with the AP and resident. The nurse stated she saw the AP push the resident "aggressively" back down into his wheelchair. She said pushing the resident back into his wheelchair if he attempted to stand was not part of the care plan. Due to the obstruction of the pillar in camera view they were unable to determine if the resident fell or if the AP pushed the resident to the floor. Other staff present in dining did not witness how the resident ended up on the floor, as they were assisting other residents serving dinner. The AP was seen holding the resident down on the ground and was heard saying he was holding the resident down. The resident was assisted off the floor and back into the wheelchair by other staff. The nurse said she spoke to the resident. The resident did not recall anything about the incident and the nurse said the resident did not sustain any injuries. The AP threatened the resident to call the police and said staff were educated not to threaten residents. The nurse stated a week prior to the resident's admission and during staff meetings, she had educated all staff including the AP, on the resident's needs. The nurse stated she informed staff the resident was impulsive, had a history of aggression, was physical with hospital staff, and would be impulsive trying to stand up. The nurse said these types of behaviors were what the facility staff dealt with; this was nothing new for staff. Staff were instructed to find the best way to approach the resident, and to redirect. All staff had received

training on dementia, behaviors, and person-centered care. The nurse stated her expectation would be if the resident was attempting to stand up, staff were to talk with the resident, redirect the resident verbally, not to physically push the resident back down.

During an interview, another nurse stated she viewed camera footage. The AP was trained that hands-on and restraining a resident was not tolerated or acceptable. The nurse said based on the AP's actions on the video; the AP lost control. The nurse stated there was nothing in the resident's care plan that indicated staff were to physically hold a resident down on the floor and stated if the resident wanted to get up and walk, the AP should have walked with the resident. The AP did not handle the situation the way he should have. The AP could have offered the resident a diversion, offered to sit with resident to eat, offered to talk with the resident, offered to go walk with the resident. The nurse stated the AP also threatened to call the police on the resident. The nurse stated it could clearly be seen on video there was no need for the police and stated calling the police would not be an intervention used in this situation.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against

the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility staff in the dining room intervened, questioned the AP as to what he was doing, and the other staff assisted the resident off the floor back into the wheelchair. Facility leadership reviewed camera footage. The AP is no longer employed at the facility.

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.

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

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
Roseville City Attorney
Roseville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33954	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF ROSEVILLE	197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113

(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: #HL339547484C/#HL339549142M #HL339549061C/#HL339549682M On March 11, 2025, 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 20 residents receiving services under the provider's Assisted Living with Dementia Care license. For #HL339547484C/#HL339549142M. No correction orders are issued. The following correction order is issued for #HL339549061C/#HL339549682M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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 two residents reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		