DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347123087M
Compliance #: HL347125082C

Date Concluded: July 6, 2023

Name, Address, and County of Licensee Investigated:
Millers Landing Senior Living
155 South 5th Avenue
Minneapolis, MN 55401
Hennepin County

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

Evaluator's Name:
Jennifer Segal, RN Special Investigator
Peggy Boeck, RN Special Investigator

Finding: Inconclusive
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), a facility staff, neglected a resident when he refused to provide requested anti-anxiety medication. In addition, the AP abused the resident when he called her names and threw a bucket of mop water at her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident stated she asked for an as needed medication and the AP denied the resident asked for the as needed medication.

Abuse was substantiated. The AP was responsible for the maltreatment. The AP yelled at the resident, called her disparaging names, and threw a bucket of mop water at her.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, incident reports, policies and procedures related to medication administration, neglect and abuse prevention and the AP personnel file. Also, the investigator toured and observed staff and resident interactions.

The resident lived in the assisted living due to mental health diagnoses. The resident's service plan included assistance with medication administration, behavioral interventions, and safety checks.

A facility investigation indicated the resident called a facility nurse one night to report the AP would not give the resident requested as needed anti-anxiety medication because the AP was on break. In a video of the incident the AP yelled at the resident and called her "dirty and nasty". The video showed the AP throw a bucket of mop water at the resident.

During an interview, a nurse who conducted the facility investigation stated the resident provided video of the incident. The nurse stated she watched the video and heard the AP yell at the resident and call the resident "dirty and nasty". The nurse stated in the video the AP was observed picking up the bucket of mop water threw it at the resident and hit her. The nurse stated the AP worked in the facility for several years and was fully trained. The nurse was surprised when she the saw the video that the AP threw the bucket of water at the resident.

During an interview, the resident stated the AP threatened her and "assaulted" her in the past but provided no specific details. The resident stated she asked the AP for medication that night, but the AP would not give it to her. The resident stated there was yelling, and she was scared. The resident stated the AP hit her with the bucket of water, and she called 911 because she was scared.

During an interview, the AP stated the night of the incident the resident followed the AP for hours to different floors insulting, screaming, and saying, "crazy things". The AP stated it was possible he called the resident names because he was "tired" of the resident. The AP stated he "pushed" the bucket at the resident. The AP stated the resident got to him that night because she "tried to piss me off". The AP stated he lost his temper and believed the resident was not a vulnerable adult. The AP stated the video did not reflect what he endured from the resident that night.

In conclusion neglect was inconclusive and abuse was substantiated.

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.

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.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, resident own responsible party.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and made appropriate reports. The facility provided retraining to staff for abuse prevention. The AP is no longer employed by 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.

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
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: ______ B. WING ______	C **06/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	**155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401**

(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: #HL347125082C/#HL347123087M and #HL347121281C/#HL347126003M On June 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 57 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL347125082C/#HL347123087M, tag identification 2360. .	0 000	The Minnesota Department of Health documents 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 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 and/or Investigators ' 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 state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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

Minnesota Department of Health

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
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 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.	