Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349636185M
Compliance #: HL349631672C

Date Concluded: August 29, 2023

Name, Address, and County of Licensee Investigated:
Seven Hills Senior Living
733 Selby Avenue
St. Paul MN 55104
Ramsey County

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

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Not Substantiated

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) emotionally abused a resident when they yelled at the resident and said they would not touch her or perform her cares. The resident indicated she was afraid of the AP and told staff she feared the AP would harm her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The alleged abuse did not meet the definition of maltreatment. During an interview, the resident denied she was abused, and did not recall specific details of the incident. The AP denied she abused the resident. The AP had no prior incidents at the facility.

The investigator conducted interviews with the facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident's record, staff schedules, personnel files, facility policies and internal investigation. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included depression and cognitive impairment. The resident's service plan included assistance with toileting, bathing, dressing and mobility. The resident's assessment indicated she required two-person physical assist for transfers and use of wheelchair for mobility. The resident was orientated to person, place, and time.

The facility internal investigation report indicated unlicensed personnel (ULP) told the facility director she overheard the AP yell, verbally abused the resident, and made racial slurs towards the resident. The ULP stated the AP refused to perform peri cares for the resident and stated threatened the resident would hypothetically be "kicked out" of the facility if she was a different race. The facility director and nurse 1 interviewed the resident, who could not recall details of the incident. A second interview was conducted by nurse 2 eleven days later when she became aware of the incident. The resident provided additional information regarding the AP's behavior and actions. The AP was suspended pending investigation, and nurse 2 reported the incident.

The personnel file of the AP did not indicate any complaints, discipline, or previous corrective actions. The AP no longer worked for the facility.

The resident's service delivery record indicated cares were completed on the day of the alleged incident.

During an interview, the ULP stated she heard the AP telling the resident she was not going to clean her, so she assisted the resident with her toileting needs when the AP walked out of the room.

During an interview, the resident denied any concerns about her care as well as ever feeling afraid of anyone. The resident stated she felt safe in the facility.

During an interview, the AP denied abusing the resident and stated the resident was verbally abusive towards her and would spit and wipe feces on her during care.

During an interview, the family member did not believe the resident was abused and was happy with the cares the resident received.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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:
(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; Stop here if it is not a restraints issue or sexual abuse.

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

Action taken by facility:
The facility conducted an internal investigation, and the AP no longer works at 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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34963	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN HILLS SENIOR LIVING	733 SELBY AVENUE SAINT PAUL, MN 55104

(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: #HL349631672C/#HL349636185M On August 17, 2023, 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 81 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for ##HL349631672C/#HL349636185M, tag identification 620, 3000.	0 000	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report suspected maltreatment immediately, within 24 hours, as required for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1's diagnosis included depression and cognitive impairment. R1's service plan dated August 4th, 2022, indicated R1 received assistance with bathing, toileting, dressing, and mobility. R1 used a wheelchair for mobility. The licensee's internal investigation report dated April 14, 2023, indicated on April 3, 2023, at 11:30 a.m., unlicensed personnel (ULP)-A informed licensed assisted living director (LALD)-E that on April 1, 2023, ULP-A witnessed ULP-B yell at R1 during her cares stating, "I'm not doing that, I'm not touching her." ULP-B continued to yell at R1 stating, "you are a privileged white person and if you were black, you would be kicked out of here."	0 620		

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0 620	Continued From page 2 ULP-B refused to perform R1's cares and walked out of R1's room, leaving ULP-A to complete all cares for R1. ULP-A filed an incident report. On April 3, 2023, at 2:30 p.m., registered nurse (RN)-C interviewed R1. R1 stated an unknown staff member [ULP-B] yelled at her for not using her pendant when she yelled for help. R1 stated the previous night ULP-B returned R1 back to her room even though R1 did not want to return to her room, stating ULP-B said she would do it anyway. R1 requested ULP-B not perform cares for her anymore. LALD-E stated she would reassign ULP-B to another area of the facility. Both LALD-E and RN-C agreed a Minnesota Adult Abuse Reporting Center (MAARC) report did not need to be completed at that time. On April 14, 2023, RN-D and LALD-E conducted a second interview with R1. R1 provided additional information stating ULP-B yelled at her, slammed items down, and made her feel ULP-B did not like her. R1 stated she was afraid ULP-B would "do something" to her. ULP-B was suspended pending the internal investigation. During an interview on August 17, 2023, at 4:13 p.m. ULP-A stated it bothered her when ULP-B verbally attacked R1, telling R1 she was not going to clean her and yelled at R1 for not using her call pendant. ULP-A stated ULP-B refused to do her job and walked out on R1. ULP-A stated RN-C and LALD-E questioned her when she told them about the incident, stating, "they acted like they didn't believe me." During an interview on August 18, 2023, at 1:01p.m, RN-D stated she did not work at the facility during the time the incident occurred. RN-D stated staff were to immediately report any suspicions of abuse. RN-D stated on April 14, 2023, she filed a MAARC report once she	0 620		

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0 620	Continued From page 3 became aware of the allegation. During an interview on August 24, 2023, at 11:02 a.m., LALD-E stated she did not initially file a MAARC report on April 3, 2023, when ULP-A informed her about R1's incident due to disagreements with other staff members on whether to file, and R1's memory. LALD-E confirmed MAARC reports needed to be filed within 24 hours. The licensee policy titled Vulnerable Adult Maltreatment, dated August 1, 2021, indicated staff were to immediately notify the LALD and RN. Additionally, a MAARC report was to be submitted, within 24 hours from the time the LALD or designee received initial knowledge of the incident. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the	03000		

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03000	Continued From page 4 previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report suspected maltreatment immediately, within 24 hours, as required for one of one resident (R1) reviewed.	03000		

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