Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL353662921M
Compliance #: HL353662718C

Date Concluded: August 14, 2024

Name, Address, and County of Licensee Investigated:
Motivate Home Services
3094 Cleveland Avenue North
Roseville, MN 55113
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, 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):
The alleged perpetrator (AP) abused the resident when the AP shut the resident in her room and would not let the resident out.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident wanted to leave the facility, but the AP told the resident to stay inside. The resident became agitated because she wanted to leave the facility. The AP brought the resident to her room and shut the door. The AP secured the door by tying a plastic bag around it, so the resident was unable to open the door and exit her room. The resident was locked in her room between five to fifteen minutes.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian and case manager. The investigation included review of the resident records, facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral palsy, fetal alcohol syndrome, and anxiety. The resident's services included assistance with activities of daily living, laundry, housekeeping, meals, and medication management. The resident's assessment indicated the resident was an elopement risk but would be allowed to sign out with her destination and time of return.

The resident's progress notes indicated the AP was verbally and physically aggressive toward the resident because the resident wanted to leave the building during inclement weather. The AP indicated the resident began to throw things, so she guided the resident to her room, closed the door, and secured the door from the outside to ensure the safety of the other residents.

The internal investigation indicated the resident was locked in her room with the door closed and fastened with a plastic bag. The AP said she secured the door to keep the resident and other residents safe.

When interviewed, a supervisor said the AP reported the resident wanted to leave the facility and the AP thought it was too cold and icy for the resident to do so. The AP attempted to redirect the resident, but the resident became increasingly agitated when she was not allowed to leave the facility. The AP said she wanted to keep the resident and her peers safe, so she guided the resident to her room and secured the door with a plastic bag to prevent the resident from being able to leave her room. Later, the AP unlocked the door, and the resident calmly left her room.

When interviewed, the AP said it was a very cold and snowy day when the resident said she wanted to leave the facility and the AP was concerned the resident would become injured if she went outside. The resident became increasingly agitated, so the AP guided the resident to her room. The AP stated she secured the resident's door with a plastic bag to prevent the resident from leaving so she could attend to other residents. The resident was asking the AP if she was going to let her out of her room and the AP stated she told the resident she wanted her to calm down so the AP could attend to other residents. The AP stated the resident was locked in her room between five to fifteen minutes and when the resident was let out of her room, she was calm.

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.

Vulnerable Adult interviewed: No, per guardian's guidance.
Family/Responsible Party interviewed: Yes, guardian contacted for consult.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and retrained staff. 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.

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
	35366	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTIVATE HOME SERVICES	3094 CLEVELAND AVENUE NORTH 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: #HL353662718C/#HL353662921M On July 16, 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 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL353662718C/#HL353662921M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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 person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		