Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366511400M
Compliance #: HL366518867C

Date Concluded: April 16, 2024

Name, Address, and County of Licensee Investigated:

Lexington Pointe Senior Living
3385 Discovery Road
Eagan, MN 55121
Dakota County

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

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 handled the resident roughly during cares and caused bruising.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP restrained the resident when he pinned the resident's arms to his chest during a brief change while the resident struggled. Following the incident, the resident had a bleeding skin tear on his arm resulting from his struggle to free himself from the AP's grasp.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a family member. The investigation included review of the resident records, death record, facility internal

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and polyosteoarthritis (widespread degenerative joint disease). The resident's service plan included assistance with activities of daily living. The resident was an assist of two when weak, using a mechanical lift.

Staff were instructed to redirect if the resident was agitated or upset. Staff were instructed to speak to the resident using slow, kind, and direct speech, and to use very direct instructions when providing cares. The resident's assessment indicated the resident was forgetful and no longer ambulatory. The resident would be unable to report abuse or neglect.

The facility's internal investigation indicated a staff member was twice called by the AP to assist with changing the resident's brief. The first time the staff member arrived, she saw the AP had already started to change the resident's brief, and the resident was halfway off the bed. The AP restrained the resident's arms across his chest as the resident struggled to get free. The AP was putting pressure and full force into pinning the resident to the bed. The staff member said the AP also used disparaging language toward the resident such as, "…you made me do this," and "this is why nobody wants to help you." The staff said the second time she helped the AP with the resident's brief change, she entered the room, and the AP was again restraining the resident to his bed. The resident appeared stressed and tried to defend himself by breaking out of the AP's restraint. After the staff and AP completed cares, the AP "whipped" the resident off the bed, and he slid off the bed. The resident sustained a skin tear on his left arm.

The internal investigation did not include a written statement from the AP but did include a termination report, due to suspected/reported abuse.

When interviewed, a supervisor said the resident required the assistance of two staff for cares. A staff member reported she felt uncomfortable with how the AP repositioned the resident. The AP held the resident's hands to his chest and was aggressive turning the resident from side to side. The staff member said the AP was holding the resident's arms down and restraining the resident. At one point, the resident developed a skin tear on his left forearm and bruising to his knee. The staff also reported the AP made disparaging remarks to the resident.

When interviewed, a staff member said on one shift she assisted the AP twice with changing the resident's brief. The staff said the AP was aggressive with the resident during cares and restrained the resident to the bed. The AP restrained the resident by standing over the bed and boosting himself up over the resident so he would have more control as the resident continued to struggle. The AP held the resident's arms across his chest as if in restraint, and the resident struggled to free himself. The staff member said the AP told the resident, "…this is the reason other people don't want to work with you, cause you're so hard to work with." The staff member said the resident fell halfway off the bed during the struggle with the AP, and then the

staff member noticed a bleeding skin tear on the resident's arm. The staff told the AP to leave the room and she would manage the rest of the resident's cares. The AP left the room briefly, but then returned and yelled something unintelligible at the resident, and the resident began to cry. The staff member said the resident was crying and very upset throughout the cares.

When interviewed, the AP said he grabbed the resident forcefully to prevent him from falling during a brief change. The AP said the resident would get angry, so staff would have to grab him "a little forcefully" while completing cares. The AP denied hurting the resident.

When interviewed, a family member said staff needed to approach the resident mindfully and explain in detail what they were doing for him when providing cares. Due to the residents dementia, the resident could become anxious, angry, and would lash out. If staff approached the resident appropriately, it would help prevent the resident from becoming combative out of fear.

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, deceased.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an 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
Dakota County Attorney
Eagan City Attorney
Eagan Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36651	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON POINTE SENIOR LIVING	3385 DISCOVERY ROAD EAGAN, MN 55121

(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: #HL366518867C/#HL366511400M On March 28, 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 50 clients/ residents receiving services under the provider's Basic/Comprehensive Assisted Living/Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL366518867C/#HL366511400M, 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.	02360	No plan of correction is required for this tag.	