

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL366513664M  
**Compliance #:** HL366516004C

**Date Concluded:** August 28, 2023

## **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:** Angela Vatalaro, 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 a resident when the AP repeatedly taunted the resident over a two-day time span. This led to the resident falling and sustaining injury.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was seen on recorded video treating the vulnerable in a manner which was derogatory, humiliating, and harassing. The AP's actions on three consecutive days caused the resident to become agitated to the point where the resident chased the AP each time and fell on two separate days sustaining injuries.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigator contacted the resident's family member. The investigation included review of the resident's record, personnel files, facility's

policies and procedures, the facility investigation into the incident, and recorded video footage. Also, the investigator observed interactions between the resident and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing, grooming, bathing, and medication administration. The resident could be resistive to cares and had agitation. Staff were directed to use a calm, quiet, soft tone of voice, keep the resident's environment quiet, provide the resident a break from conversation, knock on the resident's door when entering the apartment, and walk in slowly. The resident's vulnerability assessment indicated the resident had gotten up quickly at times and rushed staff out of her room.

The resident's record indicated one day the resident was agitated and chased the AP down the common area hall, fell, hit her nose, and sustained a nosebleed with friction burns on her nose. During an interview a nurse stated the resident chased after the AP the day she fell and hit her nose.

The next day, the facility investigation indicated recorded video footage provided to the facility showed the AP enter the resident's room. The AP brought in a portable piano to play music. The resident told the AP she did not want the AP to play music. The AP played the portable piano, and the resident chased the AP out of her room. The resident kept trying to push the AP out of her room and the AP kept coming back in. On the video the AP gestured with her fingers for the resident to come and get her. The AP continued to gesture with her fingers and continued telling the resident to come get her.

Review of the 17-minute recorded video showed the AP bring in a portable piano on a metal wheeled cart. Prior to the AP bringing in the piano, the resident told the AP she did not want to listen to music. The AP told the resident "yes" and brought the piano into the resident's apartment. The AP can be heard playing the keyboard keys hard, fast, and repetitive increasing the music volume and telling the resident to "wake up" and continued to play the music. The AP asked the resident if she "liked" the music multiple times. The resident did not respond. The AP continued to play the music. The music got louder, and the AP continued to call out the resident's name repeatedly asking if she liked it, the resident told her "no." The resident told the AP to "leave" in a loud raised voice. The AP continued to play the music, continued asking the resident if she "liked the music?" The resident repeatedly said "no", the AP repeatedly told the resident "yes." The AP again played the keyboard keys hard, fast, and repetitive increasing the music volume and told the resident she was going to "keep playing the music." The resident repeatedly said "no" and to "stop it" using a loud raised voice. The AP kept playing the music. The AP continued to ask repeatedly if the resident "liked" the music and continued to play as the resident continued to say "no" repeatedly, and the resident said she "hated the music." The AP's repetitive questions to the resident and the continued playing of the piano escalated the resident's agitation. At that point, the video shows the resident running behind the AP, chasing the AP out the apartment door. After the resident turned and reentered the room, the AP followed behind the resident calling out the resident's name multiple times. The AP verbally

told the resident to “come get” her and used hand gestures. The resident continued to repeatedly tell the AP to “get out” of her room. The resident shut the apartment door, holding the door shut. The AP pushed on the door from the opposite direction against resident, attempting to open the door multiple times while the resident pushed from the opposite direction to close the door. The repetitive actions of the AP despite the resident’s continued refusals, put the resident at a high risk for injury.

Review of a 15-minute recorded video from the next day, showed the resident lying in bed facing the wall with her back to the living area. The AP stood at the resident’s bedside asking the resident if her nose still hurt and asked the resident three times “what happened to her nose?” The AP touched the resident’s arm. The resident told the AP to not to touch her in a firm voice. The AP continued repeatedly asking the resident “what happened to her nose” seven more times and pointed at the resident’s nose while the resident laid on her side in bed. The AP used repeated verbal statements and hand gestures for the resident to “get up out of bed to look at her nose in a mirror.” The resident told the AP “no” using a raised firm voice, told the AP she was not going to look at her nose multiple times, and told the AP to “shut up.” The AP again asked the resident “what happened to her nose?” The AP told the resident she would take a picture of it. The AP left the room and returned to the resident’s room with a phone and went to foot of the resident’s bed. The AP told the resident to say “cheese,” took a picture, and showed the resident the picture. The AP told the resident to “look at the picture” and asked the resident again “what happened to her nose?” The resident did not respond. The AP stood at the resident’s bedside while saying the resident’s name multiple times and blew (loud exhale type blow) at the resident, called out the resident’s name again multiple times, and touched the resident’s leg. The resident sat up in bed, told the AP to “get out” of her room multiple times pointing at the door using a raised firm voice. The AP did not leave. The AP retrieved her phone and showed the resident the picture again, told the resident this was what her nose looked like, and asked the resident “what happened to her nose?” The resident sat on her bed with her head down. The AP turned up the volume of a radio playing music and asked the resident if she “liked the music?” The resident did not respond. The AP went to the side of resident’s bed and touched her. The resident got up out of bed and chased the AP out of her room.

Two minutes later the resident returned and stood at her dresser with her back to the video looking into a mirror. Two minutes after that the AP returned. While the resident looked in the mirror the AP went over and looked into the mirror with the resident, asked the resident “what happened to her nose” and asked the resident what happened to her “friend’s nose.” The resident stood at dresser with her head down and did not respond. While at the dresser the AP repeatedly called out the resident’s name, whistled at the resident, and made statements of “you who” towards the resident. The resident kept her head down and did not respond. The resident went and laid in bed facing the wall with her back to the AP not making eye contact with the AP. The AP continued to call out the resident’s name, whistled, and continued saying “you who” toward the resident. The resident did not respond and kept facing the wall. The AP went over to the foot of the bed and touched the resident. In one quick motion, the resident turned, sat up, stood, lost her balance, fell, and hit her forehead on the nightstand. With the

resident on the floor and crying loudly, the AP asked the resident if she was okay and asked the resident if she “wanted to dance?” The AP did not attempt to assist the resident. Another staff member entered the room, told the AP to turn off the music and asked the resident what happened. The resident was unable to describe what occurred. The staff member asked the AP what happened, the AP said the resident fell.

During an interview, unlicensed personnel (ULP) stated she was down the hall and heard the resident yell then heard the music volume turn up. The ULP stated she entered the resident’s room and found the resident sitting on the floor with her back against the bed, holding her eye, crying, saying her eye hurt. The resident’s eye had started to swell. The unlicensed staff member stated the music volume was turned up loud enough where she could not hear the resident speaking. The ULP stated she asked the AP to turn the music down. The ULP stated she got another co-worker to assist getting the resident off the floor.

During an interview, a nurse stated one day she was investigating the resident’s previous fall and watched recorded video footage. The resident chased the AP down the common area hall, tripped on the carpet, fell, and sustained a bloody nose. After that fall, video footage showed the AP in the resident’s room. The AP had the resident look at her injured face and nose. The AP used repeated visual gestures and verbal statements, telling the resident to come and chase her. The nurse stated on the recorded video the resident did not want to listen to music. The nurse stated it was evident by the resident’s facial expressions and the resident’s statements she did not like the music, to stop, and to get out of her room. The AP did not leave and turned the music up louder. The nurse stated the AP continued to taunt the resident which made the resident angry, upset, and agitated. The nurse described the taunting as continual teasing and egging the resident on. The resident repeatedly told the AP to leave and to get out of her room. The AP did not leave, and the resident showed increased agitation. The nurse stated the video showed the resident was highly agitated when the AP went over and touched her while in bed. The resident jumped up, fell, hit her eye on the nightstand which caused a black eye.

During an interview, facility leadership stated she watched the recorded videos. The AP was in the resident’s room on two consecutive days. The resident told the AP repeatedly to stop, leave, and to get out of her room both days. The AP did not leave and played the music louder. Facility leadership stated there was not a time where the resident appeared engaged or interested in the music activity. The resident had previously chased the AP down the hall, fell, and injured her face. Recorded video from the resident’s room showed the AP repeatedly ask the resident to look at her facial injury and repeatedly ask the resident what happened. Leadership stated the recorded video showed the AP taunted the resident using finger gestures telling the resident to come and get her.

During an interview, another member of leadership stated the AP received training to leave the resident’s room when the resident refused to participate in an activity.

During an interview, the AP stated one day with the resident sitting at the dining room table, the AP approached the resident and blew on her. The resident became upset, chased the AP down a hallway, fell and injured the resident's nose. The AP demonstrated the blow during the phone interview. The blow was an audible, quick, exhale, type sound. The next day, the AP went to the resident's room to offer a music activity and asked the resident about her facial injury and what happened. The AP stated she encouraged the resident to chase her. The AP stated she was aware the resident did not want to participate with activities because the resident was agitated and refused the activity. The AP stated she played the music for the resident despite the resident's refusals. The AP stated she did not leave the resident's room when the resident asked her to leave. The AP stated the next day she did not leave the resident's room when the resident asked her to leave. Over time, the resident became more upset with the AP, jumped out of bed, fell, and hit her eye when attempting to get the AP out of her room. The AP stated her actions were wrong and provided no additional explanation for the treatment of the resident.

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, unable due to cognition.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility conducted an internal investigation. The AP was 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  
Dakota County Attorney  
Eagan City Attorney  
Eagan Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36651</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/06/2023</b>
--	--	---	---

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

(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	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p>#HL366514956C/#HL366513042M #HL366516004C/#HL366513664M</p> <p>On July 5, 2023 through July 6, 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 163 active residents, 43 of whom received services under the Assisted Living with Dementia Care license.</p> <p>No correction orders are issued for #HL366514956C/#HL366513042M.</p> <p>The following correction order is issued for #HL366516004C/#HL366513664M, tag identification 2360.</p>	0 000	<p>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 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 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 evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
02360	<b>144G.91 Subd. 8 Freedom from maltreatment</b>	02360		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36651</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/06/2023</b>
--	--	---	---

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

(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
02360	<p>Continued From page 1</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360	No plan of correction is required for this tag.	