*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL367381323M
**Compliance #:** HL367388842C

**Date Concluded:** May 3, 2024

**Name, Address, and County of Licensee Investigated:**

Stonecrest Living
5022 Baker Rd
Minnetonka MN 55343
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Maggie Regnier
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 client when the AP spit in the face of the resident.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was substantiated. The AP, who was an unlicensed caregiver, was responsible for the maltreatment. The AP and the resident got into a verbal altercation when the AP then spit in the resident's face.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, and the case worker. The investigation included review of the resident's record, incident reports, internal investigation notes, the AP's personnel file and trainings, and the facilities policies. Also, the investigator observed staff and resident interactions, staff and staff interactions, and the resident's living area.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar II disorder, obsessive compulsive disorder (OCD), major depressive disorder and psychosis. The resident's service plan included medication and behavioral management. The resident's assessment indicated he has his own decision-making authority. The resident's behaviors related to OCD included not wanting to be touched or his belongings to be touched, covering touch surfaces with paper towels or plastic bags, and excessive hand washing.

The facility's internal investigation document indicated the AP was working when the resident saw the AP blow his nose on the floor of the facility. The resident told the AP to clean it up and called the AP a pig. The AP then got up and threatened to clean the resident's room. This upset the resident and they both ran towards the resident's room when the resident stood in front of the stairs and hallway leading to his room, the AP spit on the resident.

The internal investigation document also indicated the facility's security cameras had the incident on video and was reviewed by facility leadership, nursing staff and police officers.

A law enforcement document indicated the AP was interviewed and admitted to spitting the resident in the face. This same document indicated the AP would be charged with a gross misdemeanor for this event.

During an interview, facility leadership stated the surveillance camera video was reviewed and clearly showed the AP spiting on the resident.

During an interview, the resident stated he did not think the AP would spit on him and was shocked when he did. The resident stated he was very upset with this and immediately washed his face. He was surprised and shocked by the behavior. The resident also stated the AP threatened to clean the resident's room because he knew the resident did not like it when anyone touched his belongings.

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**: Yes
**Family/Responsible Party interviewed**: None
**Alleged Perpetrator interviewed**: Attempted but not successful.

**Action taken by facility:**
The facility terminated the AP and then did supplemental education to all staff on what is maltreatment.

**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
Minnetonka City Attorney
Minnetonka Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36738 | A. BUILDING: _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONECREST LIVING | 5022 BAKER ROAD MINNETONKA, MN 55343 |

| (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<br><br>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL367388842C/#HL367381323M<br><br>On April 16, 2024, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 9 clients/ residents receiving services under the provider's Assisted Living license.<br><br>The following correction order is issued/orders are issued for #HL367388842C/#HL367381323M , tag identification 2360. | 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 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, | 02360 | | |

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| 02360 | Continued From page 1<br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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. | |