DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL384124262M
Compliance #: HL384124996C

Date Concluded: August 28, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care
1880 134th St S
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Inconclusive

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) physically abused and verbally abused a resident when the AP swore and struck out at the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While the AP did not use verbal good clinical technique to de-escalate his behavior, the statements did not meet the definition of abuse. Additionally, there was a physical altercation between the resident and the AP, the video was obscured by furniture at the moment abuse may have occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's progress notes, care plan, facility incident report, vulnerable adult policy, and review of video footage. Also, the investigator made an onsite visit to the facility to observe memory care unit and staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease. The resident's service plan indicated the resident was able to ambulate independently, and a history of inappropriate physical/verbal altercations. The resident's assessment indicated the resident was not always orientated and required redirection and reorientation. This same assessment indicated the resident had a history of paranoia, anxiety, and obsessive/repetitive behaviors.

The resident's Individual Abuse Prevention Plan (IAPP) indicated the resident lacks orientation and was unable to understand and/or follow instructions. The IAPP indicated caregivers were to use clear and simple cues and reminders. This same plan indicated vulnerability with prescribed medications as staff administer all prescribed medications and are to notify nursing promptly with any changes. The resident required a secured memory care unit due to risk of wandering and elopement and was at risk of abusing other vulnerable adults.

The investigation included a review of facility security camera footage in two separate clips each about 30 seconds long, which included audio.

The first video showed resident sitting on the couch and had turned to say something to AP who was not right next to him but rather among the dining room tables and chairs several feet away. The AP turned to wipe down a table while the resident stood up, told her 'Get out of here' as he got up, and walked towards her. As she turned to face him, he pushed her back by placing his hands on the front of her shoulders and pushed her backwards and then swung his right arm hard against her hands as his behavior quickly escalated. The time elapsed on the video from when he was sitting on the couch to pushing her backwards was approximately 15 seconds. For the next remaining 15 seconds of the video the resident continued to push the AP back and she turned toward the secured door as he followed. She turned to address him and stepped forward, but he continued to push her back as the video ended.

The second video continued where the first left off as the both the resident and the AP tumbled onto the floor back towards the dining room. The AP was saying very loudly for the resident to stop putting his hands on her as she swore at him. The resident fell backwards onto his back while the AP fell to her knees. As the AP got to her feet her right leg lunged far out to the right as she sidestepped away from the resident and her left arm swung in a swatting motion down towards the resident. The camera view at that moment is obscured by a table and chair so that the resident and the APs hand is not visible. As the AP's left leg comes into view, her pant leg stretched as if her leg was being held back. The AP walked back towards the secured door and enters a code while telling the resident he was going to "jail". Meanwhile the resident got himself off the floor and walked towards the AP. The AP finished entered the code, exited the room, and the resident remained there alone.

The facility document regarding the incident indicated the facility nurse and management were notified. The internal investigation indicated the event took place in the early morning hours in the dining room and only the resident and the AP were present.

The progress notes indicated the resident's behaviors had been increasing over the last two months with refusals of medications documented. The same documents indicated his aggression increased when family was not able to visit. The progress notes indicated that as the resident continued to refuse his medications, he started accusing people of things and/or hallucinate someone was leaving with his vehicle. The facility followed up with the family, the resident, and the provider regarding noncompliance with his medications.

During an interview, a manger stated video and audio footage of the incident was reviewed. The incident occurred at the end of the overnight shift when residents in the unit were still in bed and one caregiver was in the unit.

During an interview, facility nurse #1 stated three-to -four weeks prior to the incident the resident began refusing his medications. Facility nurse #1 stated with the refusal of medications including his psychotropic medications his behaviors were slowly cycling out of control.

During an interview, facility nurse #2 stated she had received reports from caregivers regarding numerous times the resident had been refusing all medications. Facility nurse #2 stated she notified the primary care provider, family member, and upper management about the resident becoming progressively more verbal and confrontational with staff members. Facility nurse #2 stated the resident was being followed by a behavioral practitioner. Facility nurse #2 felt during the incident when the caregiver swore at the resident this as this did not help de-escalate his behavior.

During an interview, multiple unlicensed caregivers stated each time the resident refused his scheduled medication staff reported this to the nurse. Caregivers stated they had dementia training and attempted interventions but redirecting the resident was unsuccessful.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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
Family/Responsible Party interviewed: No, attempted but did not respond.
Alleged Perpetrator interviewed: No, attempted but refused.

Action taken by facility:
Caregiver is no longer employed by the facility. The resident later transferred to a different facility.

Action taken by the Minnesota Department of Health:
No further action at this time.

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
	38412	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF BURNSVILLE	**1880 134TH STREET EAST BURNSVILLE, MN 55337**

(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: HL384123080M/HL384123000C HL384124262M/ HL384124996C On July 18, 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 28 Residents receiving services under the provider's Assisted Living with Dementia Care license. No correction orders are issued.	0 000		