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 #: HL387838724M
Compliance #: HL387836147C

Date Concluded: March 6, 2024

Name, Address, and County of Licensee Investigated:
Camilia Rose Assisted Living
11800 Xeon Boulevard Northwest
Coon Rapids, Minnesota 55448
Anoka County

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

Evaluator's Name: Nicole Myslicki, 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 slapped her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. AP1 was responsible for the maltreatment. AP1 did not assist the resident up off the floor after a fall by means of punishment, so the resident remained on the floor for multiple hours during the night. Additionally, the resident reported to facility staff she had been slapped, and an agency unlicensed personnel (ULP) witnessed AP1 slap the resident. AP1 and an evening shift ULP (AP2) worked together during the evening shift. AP1 and the agency ULP (AP3) worked the night shift during the time of the incident.

In addition, the Minnesota Department of Health determined neglect was inconclusive for AP2 and AP3. The resident had a fall at approximately 9:30 p.m., but video footage showed AP2 bring a Hoyer lift (mechanical lift) to her room to lift the resident off the floor. Video footage

showed AP2 last check in the resident's room at 11:00 p.m. but did not enter prior to ending her shift. It was not determined when the resident had a second fall between 9:40 p.m. and 11:37 p.m., when AP3 witnessed the resident on the floor. Although, AP3 witnessed AP1's abuse of the resident AP3 did not report the incident to her agency supervisor until after the shift was over. It was AP3's first shift in the facility and directed by AP1 to leave the resident on the floor. It was unclear why AP3 waited to contact her supervisor. AP3 did attempt to contact her supervisor after witnessing AP1 slap the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed toileting.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and seizures. The resident's care plan included assistance with transferring and toileting. The resident's assessment indicated the resident needed the help of one staff to transfer and needed occasional standby help to walk at the time of the incident.

An incident report indicated the resident fell in her bedroom and found sitting on the floor, yelling for help around 9:30 p.m. AP1 documented this incident report, and the licensed assisted living director (LALD) reviewed it.

The facility's internal investigation documented the security footage review during the time of the incident. Security footage showed AP1 and AP2 enter and exit the resident's room multiple times between 9:28 p.m. and 9:44 p.m. AP2 brought a mechanical lift into the resident's room at 9:35 p.m. and left the room with it at 9:39 p.m.

The internal investigation included an interview with AP2. During this interview, AP2 stated she helped the resident off the floor with the mechanical lift around 9:30 p.m. The internal investigation did not indicate activity occurred at the resident's room between 9:45 p.m. and 11:00 p.m. Security footage showed AP2 checked in on the resident at 11:01 p.m., appearing to speak with the resident from the doorway. After this, AP2 left the facility.

The interview with AP2 in the internal investigation indicated AP2 reported the resident had been in bed when she finished her shift.

Security footage showed AP1 entered the resident's room at 11:15 p.m. and exited the room one minute later. At 11:31 p.m., AP3 arrived at the facility. AP1 pointed to AP3 to check on the resident at 11:37 p.m. At 11:39 p.m., the resident's call light came on. AP1 entered the resident's room and then left the room at 11:40 p.m.

The internal investigation included an interview with AP3 who reported AP1 asked her to check on the resident after she arrived to the facility around 11:30 p.m. AP3 saw the resident on the floor and notified AP1. AP1 told AP3 to leave her on the floor, stating that was how they dealt with the resident since she fell all the time. AP3 offered to help get the resident off the floor, but AP1 told her no. AP1 told AP3 she should not be bothered because the resident was a known fall risk and she made sure the resident was comfortable with a pillow and blanket [on the floor].

At 12:41 a.m., AP1 and AP3 looked into the resident's room but did not go inside. The internal investigation did not indicate any activity involving the resident occurred after 12:42 a.m. until AP1 looked in the resident's room at 4:06 a.m.

A second incident report indicated the resident fell from her bed and yelled for help about 4:35 a.m. AP1 documented this incident report, and the LALD reviewed it.

Security footage showed at 4:33 a.m., one of the overnight staff (the facility did not document if it was AP1 or AP3) brought the mechanical lift into the resident's room. One of the overnight staff removed the mechanical lift from the room at 4:36 a.m. The resident left the room at 4:56 a.m.

The internal investigation indicated AP3 stated the resident had been on the floor from the time she arrived until she and AP1 got her up at 4:30 a.m. AP3 stated she told AP1 they should pick up the resident around 11:30 p.m., 2:30 a.m., and 4:30 a.m. During those rounds, AP3 said AP1 said now was the best time to get the resident off the floor. When AP1 and AP3 finally assisted the resident off the floor, the resident was angry, hitting out and trying to kick the Hoyer lift. AP3 said while removing the sling, the resident did not want AP1 to touch her began spitting at AP1. AP3 reported AP1 then used slapped the resident on her cheek. The resident started crying. AP3 asked AP1 why she slapped her and AP3 reported AP1 stated the resident was hard to handle.

The internal investigation also included an interview with the resident. The resident stated she fell on the floor. When asked if someone had told her to stay on the floor, she stated "yes." The resident also stated someone hit her and pointed to her cheek.

During an interview, a facility ULP stated she worked the morning shift after the incident occurred. The resident told her she had been on the floor all night and that someone hit her.

During an interview, a family member stated the resident's falls were becoming more and more frequent. The resident was supposed to call and ask for help to go to the bathroom but would get up then quickly realize she did not have the strength or ability. The resident called the family member and told him what happened after the incident occurred. The resident reported AP1 had been frustrated she fell. AP1 told the resident she needed to sleep on the floor for the night. The resident attempted to crawl over to her bed, but she did not have the strength.

When AP1 returned to get her back up, the resident did not respond well, so AP1 backhanded her.

During an interview, AP1 stated she and AP3 found the resident on the floor during rounds in the four o'clock hour in the morning. AP1 denied slapping or hitting the resident.

AP2 failed to make herself available for a private interview. AP3 failed to respond to a subpoena.

In conclusion, the Minnesota Department of Health determined abuse was substantiated against AP1. The Minnesota Department of Health determined neglect was inconclusive regarding the allegation against AP2 and AP3.

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.

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:
(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;

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: AP1; Yes. AP2; No. Attempted, but AP2 failed to be available for scheduled interviews. AP3; No, failed to respond to subpoena.

Action taken by facility:
The facility completed an internal investigation. AP1's employment and AP2's employment ended. The facility completed education with facility staff after the incident.

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
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38783	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE ASSISTED LIVING	11800 XEON BLVD NW COON RAPIDS, MN 55448

(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: #HL387836147C/#HL387838724M On January 25, 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 15 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL387836147C/#HL387838724M, 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 License Providers. 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 surveyors' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) 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.	