Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL398194602M
Compliance #: HL398195901C

Date Concluded: September 16, 2024

Name, Address, and County of Licensee Investigated:
The Meadows Senior Living
6555 Loftus Lane West
Savage, MN 55378
Scott County

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

Evaluator's Name: James P. Larson, 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), a facility staff member, abused the resident when the AP pushed the resident in retaliation to the resident being uncooperative.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting accounts provided, there was not a preponderance of evidence to support that the actions of the facility staff member met the definition of abuse. The resident was evaluated and treated at a local hospital and returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator also contacted family members and hospital staff. The investigation included review of the resident record, hospital records, facility internal investigation documentation, personnel files, staff schedules, and facility policies and

procedures. The investigator also toured the facility, observed staff members interacting with residents, and observations of medication administration.

The resident resided in an assisted living facility memory care unit with a diagnosis of dementia. The resident's service plan included assistance with activities of daily living, medications, meals, housekeeping, and safety checks. The resident's assessment indicated the resident required assistance, redirection, and cueing for incontinence issues and had a history of falls.

Facility documentation indicated that over one weekend two incidents occurred between the resident and a facility staff member/alleged perpetrator (AP). The AP reported that the resident became upset after she attempted to redirect the resident to other areas of the facility. One incident occurred after being asked to leave the kitchen and a second incident the following day after being found in another resident's room. After verbal attempts of redirection failed, the AP physically led the resident out of the area and the resident became upset and fell after becoming physically aggressive with the AP. Following the second incident, the resident was transported to a local medical facility for behavioral evaluation and observation. It was later reported to facility management that the AP may have pushed the resident during the altercations causing the resident to fall.

Video surveillance footage reviewed did not include footage of the entirety of the incidents and it was unable to be determined if the AP pushed the resident.

During an interview, the AP stated that she was aware and understood proper procedures for verbal redirection, although admitted that she led the resident by the arm to another area. The AP stated that she was in a defensive posture during the incidents as she was attempting to protect herself while repeatedly being grabbed and struck by the resident. The AP denied striking or pushing the resident in retaliation during the interactions.

During an interview with a registered nurse, she stated that she was informed that the resident had fallen during an altercation with the AP. The AP reported that the resident stepped backwards and tripped over their [the AP's] feet which caused him to fall. The following day, the AP notified the nurse that the resident grabbed her arm, pushed her, and had a hand on her throat. The nurse stated that this was an isolated incident and prior to this timeframe no other concerns were brought to her attention concerning either the resident or the AP.

During an interview, a hospital staff member stated she was informed of the incidents by the resident's family members but was unable to verify if the facility followed up on the alleged altercations. The hospital staff stated that the family had no additional concerns over the care provided at the facility and felt this was an isolated event.

The resident was interviewed but was unable to recall the incident.

During an interview with a family member of the resident, they stated they were contacted by the facility about both incidents. The family member did not have concerns with the care provided by the facility.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The AP was re-educated following the incidents and is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
No further action taken 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
	39819	A. BUILDING: _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS SENIOR LIVING	6555 LOFTUS LANE SAVAGE, MN 55378

(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 On July 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL398195901C/#HL398194602M. No correction orders are issued.	0 000		