Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339543184M **Date Concluded:** February 24, 2023

Name, Address, and County of Licensee Investigated:
Suite Living of Roseville
197 County RD B2 West
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Yolanda Dawson, 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):
An unknown facility staff member/alleged perpetrator (AP) abused a resident when bruising was found in the resident's peri area.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was inconclusive. While it was reported by the hospital nurse that the resident had perineal trauma, an alleged perpetrator could not be identified, and it was unable to be determined if sexual abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, internal investigation notes, and external medical records. Also, the investigator observed staff members provide assistance with activities of daily living for several residents.

The resident resided in an assisted living facility. The resident's diagnoses included memory loss, dementia, psychotic disturbance, mood disturbance, and anxiety. The resident's service

plan included bathing and toileting assistance, and assistance with all activities of daily living. The resident's assessment document indicated the resident was vulnerable to abuse due to a diagnosis of dementia and inability to verbally communicate her needs.

The resident's hospital record indicated the resident was admitted for altered mental status and elevated blood sugar. The nursing assessment found perineal bruising. A sexual assault exam was completed, and additional perineal trauma was found. The resident was largely nonverbal and was unable to provide information regarding care provided at the facility or the possibility of sexual assault.

The facility completed an internal investigation upon learning of the observed bruising. The internal investigation notes indicated the resident admitted to the facility four days prior to the hospital admission. An initial assessment, which included a skin assessment, was completed upon the resident's admission to the facility. The nurse who completed the assessment also assisted with an incontinent product change that same day and did not observe any bruising to the resident's perineal area. Multiple unlicensed staff were interviewed who stated they did not observe bruising on the resident while assisting with cares. A review of video imaging was completed which did not display unusual activity by residents or staff members and provided no further information into the alleged incident.

During an interview, a staff member stated she provided care for the resident in the days leading up to her hospitalization. The staff member stated she did not see any bruising while providing toileting assistance and had not observed any change in the resident's behavior or any other signs or indications that the resident had been abused.

During an interview, the facility nurse stated she completed the resident's initial assessment. At the time of the assessment no bruising was observed and there were no other indications of abuse. The nurse stated the facility investigation was unable to identify the cause or source of the bruising. No alleged perpetrator was identified, and it was unable to be determined if abuse occurred.

In conclusion, the Minnesota Department of Health determined sexual 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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: None identified.

Action taken by facility:
The facility completed an internal investigation when they became aware of the bruising.

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
	33954	A. BUILDING: _____ B. WING _____	C 11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF ROSEVILLE	197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113

(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 November 15, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL339543184M. No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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. 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	

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0 000	Continued From page 1	0 000	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	