Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36021007M
Compliance #: HL36021008C

Date Concluded: October 3, 2022

Name, Address, and County of Facility Investigated:

The Preserves of Roseville
2600 Dale Street North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Inconclusive

Nature of Visit:
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.

Allegation(s): The Minnesota Department of Health determined neglect was inconclusive. There was a lack of evidence to support the AP yelled at the resident making the statement: "shut-up or I will slap the shit out of you" after the resident, alleged, made a racial comment towards the AP.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There was a lack of evidence to support the AP was responsible for the maltreatment. Facility administrative nursing staff that interviewed the AP during a facility investigation, stated when the AP was asked if he told the resident to: "shut up or I will slap the shit out of you", he told the administrative nursing staff: "She [resident] should know better" then, threw his keys on the desk, walked out of the facility and did not return. Two other unlicensed personnel heard the

AP swear at the resident at the time of the incident and one of the unlicensed personnel heard the AP make the comment to the resident. The facility was unable to locate the facility internal investigation that was allegedly completed after the incident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's medical records were reviewed. The facility's pertinent policy and procedures were reviewed. Facility training records were reviewed. The facility's pertinent incident reports were reviewed.

The resident's diagnoses included: bipolar disorder and hypothyroidism (thyroid does not create enough hormone). The resident's Individual Abuse Prevention Plan (IAPP), indicated the resident had scores indicative of dementia, was on medications to treat anxiety and depression. This same IAPP also included staff speaking slowly to the resident and repeating as necessary due to communication deficits.

The facility's investigation questionnaire forms completed by two unlicensed personnel, indicated [handwritten],the AP's name, the resident's name, a racial "slur" occurring one evening in the dining room area and in quotations without any other reference or details: "slap the shit out of you". Another questionnaire indicated next to the AP's name and handwritten: -said: "he would hit her if he was not at work". The handwritten note did not indicate who "he" or "her" was. Neither notes on the questionnaires were dated or had times.

During an interview, unlicensed personnel stated remembering the incident occurred in the dining room but did not remember the resident making a racial comment. This unlicensed personnel stated hearing the AP telling the resident: "I will slap the shit out of you" but could not remember the resident's reaction to the comment. This unlicensed personnel informed the nurse of the incident immediately.

During an interview, an administrative nurse stated the incident was reported to her in the evening. The administrative nurse stated the AP's response when asked if he had said the statement was: "she should know better", then threw the facility keys on the desk, left the facility, and never returned.

During an interview, a staff nurse stated the AP approached her to request that the resident be disciplined for making racial comments. The staff nurse educated the AP on the effects of dementia.

During an interview, another unlicensed personnel stated observing the incident and stated she tried to calm the AP down after the AP cursed at the resident.

During an interview dated, the AP stated the resident made the racial comment of: " That boy is going to take me to my room" and denied telling the resident that if she did not shut up, he would slap the shit out of her, but did state he [AP] had spoken to the resident in a "pissed-off"

manner, telling the resident that her remark was racist. The AP also stated the resident did not say anything after she made the racial comment, and another unlicensed personnel took the resident to her room after the comment. The AP stated he was then called to the office where he told administrative nursing staff that it would be wrong if he slapped the hell out of the resident.

During a second interview, the same administrative nurse stated the AP did not admit to saying the statement to the resident: “shut up or I will slap the shit out of you”, but the AP stated: “She should have known better” and “I didn’t think she [resident] should have talked to me like that” then turned in his keys and left the facility. This same administrative nurse stated the AP’s comment during a facility counseling meeting would have been in the facility internal investigation. This same administrative nurse stated the resident was interviewed after the incident and this information could also be found in the facility internal investigation. The administrative nurse stated she had the facility searching for the facility internal investigation.

Two separate facility emails from two separate facility administrative nursing staff indicated the facility internal investigation for this incident could not be located.

In conclusion, it was inconclusive if abuse 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:
(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 due to impaired cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed at the facility.
The facility conducted additional, mandatory, dementia training, including six to eight hours of hands-on dementia training, with all staff members.

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
	36021	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH 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 Initial comments On June 23, 2022, the Minnesota Department of Health initiated an investigation of complaints: #HL36021008C/#HL36021007M #HL36021010C/#HL36021009M #HL36021013C/#HL36021012M No correction orders are issued.	0 000		