Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370041545M **Date Concluded:** March 22, 2023

Name, Address, and County of Licensee Investigated:

Grace Assisted Living LLC
15300 Dundee Court
Apple Valley, MN 55124-5887
Dakota County

Facility Type: Assisted Living Facility (ALF) **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.

Initial Investigation Allegation(s):
The unlicensed staff member/alleged perpetrator (AP) verbally abused two residents when the AP told Resident #1 in front of Resident #2, that "he stunk", and his clothing needed to be changed. The AP then told Resident #2 to "shut the fuck up," after Resident #2 told the AP that she should not be talking to Resident #1 like that in front of other residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined verbal abuse was inconclusive. It is unable to be determined what the AP said to the residents. Conflicting information was documented and provided by the residents, the facility, and the AP. In addition, there was a discrepancy between information provided; Resident #2 stated he was witness to the incident, and facility administrative staff reviewed video footage and indicated no additional residents were present at the time of the alleged incident.

The investigator conducted interviews with facility staff members, including administrative staff. The investigator conducted interviews with residents and contacted law enforcement. The

investigation further included review of resident medical records, personnel records, and relevant facility policies. During the onsite visit, the investigator conducted observations of facility staff's interactions and communication with residents.

Resident #1:

Resident #1 resided in an assisted living facility. The resident's diagnoses included bipolar depression and type 2 diabetes. The resident's service plan included daily assistance with medication administration, activities of daily living (ADL's) such as, dressing, hygiene, and incontinence. The resident's assessment indicated the resident had a tendency towards self-neglect due to behavior.

Resident #1's medical records indicated after visiting a family member, the resident returned to the facility with soiled clothing from being incontinent of feces. Notes within the medical record identified that the unlicensed staff member (ULP)/alleged perpetrator (AP) politely and softly asked the resident to take a shower. The resident agreed but sat down in front of his computer and fell asleep for an hour. When the resident woke up, the chair was soiled with feces and the smell had drifted out to the facility kitchen area. The AP then asked the resident to take a shower, to which the resident refused but, instead, went to a bathroom and changed his clothes.

A facility grievance form completed by Resident #1 with assistance from a facility administrative staff member, indicated the incident occurred in the facility common living room. The grievance form indicated the resident was yelled at when he refused to take a shower and change his clothes. This grievance form further included the resident said he was "not abused, just yelled at". The facility administrative staff explained to the resident that the AP looks like she is yelling but is only talking loudly. The resident replied with "ok" and provided an apology. The facility administrative staff member documented on the grievance form, that facility video cameras were reviewed and there was no evidence of abuse.

Resident #2:

Resident #2 resided in an assisted living facility. The resident's diagnoses included Gilles De La Tourette's Syndrome (a neuropsychiatric disorder characterized by multiple motor and vocal tics) and bipolar mood disorder. The resident's service plan included daily assistance with activities of daily living (ADL's) such as: medication administration, oral hygiene, hair care, and twice per week staff assistance with grooming. The resident's individual abuse prevention plan, (IAPP) indicated the resident was able to report abuse.

Resident #2's medical record indicated the AP was talking to Resident #1 when Resident #2 started yelling at the AP. The AP told Resident #2 not to interfere with the conversation between the AP and Resident #1. After that interaction, Resident #2 called 911.

During an interview, Resident #2 stated he felt Resident #1 had been treated very badly. The AP told Resident #1 that he had "shit in his pants and needed to take a shower". Resident #2 stated

the comments from the AP were said while both residents were sitting in the facility common area. Resident #2 stated after the comments were made, Resident #1 was observed to be hurt and upset, and that his (Resident #1) posture changed to slouching and he became very quiet. Resident #2 called 911 regarding the incident.

A law enforcement document dated the day after the incident, indicated the incident was reviewed and there was no need for law enforcement to be involved.

During an interview, facility administrative staff stated they became aware of the incident when the AP called immediately after the incident occurred. Facility administrative staff conducted an interview with Resident #1, who reported the AP yelled at him to take a shower. After the interview with the AP and Resident #1, the facility administrative staff reviewed facility video footage and did not observe any inappropriate language used on the part of the AP. The facility administrative staff stated there were no other residents present during the incident.

Facility video footage was not available to be reviewed by the investigator.

During an interview Resident #1 stated he felt sad after the AP spoke to him about having an odor.

The AP is no longer employed by the facility and did not respond to requests for interview.

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 (s) interviewed: Yes, both Resident #1 and Resident#2
Family/Responsible Party interviewed: No, resident(s) responsible for self
Alleged Perpetrator interviewed: No. Attempted to reach AP four times with no response. AP no longer employed at facility.

Action taken by facility:
None

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
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