Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL215836041M
Compliance Project: HL215838721C

Date Concluded: December 17, 2024

Name, Address, and County of Licensee Investigated:
Walker Methodist River Heights
744 19th Ave N
South St. Paul, MN 55075
Dakota County

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

Evaluator's Name: Deb Schillinger RN BSN
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), an unlicensed caregiver, abused the resident when she shaved his head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP shaved the resident's hair without although it was not part of his service plan nor was she directed to do so. Afterwards, the resident acted in a way indicating he found having his head shaved bald humiliating.

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

Also, the investigator made an onsite visit to the facility to observe memory care unit and staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with grooming and bathing. The same document indicated the resident ambulated with a walker. The resident's assessment indicated the resident was unable to protect himself or report abuse and could be combative when upset.

A facility report indicated unlicensed caregiver #1 found the resident hiding under his bed covers after his head had been shaved and he was upset about it. The same incident report indicated the AP said she shaved the resident's head because it was getting too long. Unlicensed caregiver #1 observed he had bald patches along with areas of long hair left and offered to help him, which he accepted. Unlicensed caregiver #1 trimmed his hair to be even, stayed with the resident until he felt better, and contacted the nurse.

An internal investigation indicated when the AP was questioned, she admitted she cut the residents hair and claimed she thought the family had given consent to cut the resident's hair. When asked if the family had authorized shaving his head bald, the AP replied she did not know. However, the facility had already contacted the resident's family who had denied giving permission to cut his hair, although trimming his beard had been authorized. The AP's employment ended at the time of this discussion.

During an interview, a manager stated she learned of this incident when unlicensed caregiver #1 called to report it. The manager stated she notified the family member, who stated consent was not given to cut the resident's hair and found this upsetting. The family member stated the resident would not have been able to give consent nor would he have wanted his head shaved, as he had always been very particular about his hair.

During an interview, unlicensed caregiver #1 stated when she first learned the AP had shaved the resident's head, the AP said, "Ha-ha, did you see what I did to [the resident]?" Then, the AP led her to the resident's room where he was laying on the bed with his head under the blankets, whimpering, upset and crying. Unlicensed caregiver #1 stated the AP said she cut his hair because he looked "homeless". When unlicensed caregiver #1 found the resident, he had patches of long hair with bald spots over his head and the AP told her the resident had fought with her so she could not finish. When told she should not have cut the resident's hair without consent from the family, the AP shrugged her shoulders and walked away. After calming the resident, he allowed her to "fix" his hair, so it was the same length, and she contacted the manager. Unlicensed caregiver #1 stated the resident prior to this incident the resident would come out of his room and interact with others. However, for the next few days he mostly stayed in his room.

During an interview, an unlicensed caregiver #2 stated the resident's hair was cut "completely bald" and, after the incident, the resident did not want to leave his room and he would cover

his head with his blankets. Unlicensed caregiver #2 stated she felt it several days for his demeanor to return to baseline after his dignity had been taken from him.

During an interview, the AP stated she knew she should not have done it nor did she know why she did it. The AP stated that unlicensed caregiver #2 finished cutting the resident's hair after she did. The AP stated the resident did not fight with her while cutting his hair.

During an interview, a family member stated she received a call that someone had cut the resident's hair, she stated she was not notified prior to nor given permission for this. The family member stated the resident's head was shaved bald and he would not want his head to be shave as he had always been very particular about his hair.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

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.

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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(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: Attempted but unable due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation. The AP was no longer employed at the facility.

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
Dakota County Attorney
South St. Paul City Attorney
South St. Paul Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21583	A. BUILDING: _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST RIVER HEIGHTS	744 19TH AVENUE NORTH S ST PAUL, MN 55075

(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: #HL215838721C/#HL215836041M On November 26, 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 46 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL215838721C/#HL215836041M, 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 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 USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial 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 residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person wa responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		