Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:
HL304453225M / HL304456586M
Compliance #:
HL304455263C / HL304452429C

Date Concluded: December 22, 2023

Name, Address, and County of Licensee Investigated:
The Lodges on Summit Oaks
1412 Summit Oaks Drive
Burnsville, Minnesota 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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):
Allegation #1: Alleged perpetrator (AP)1 abused resident 1 when AP1 yelled, made disrespectful comments, and refused to assist resident 1 to eat dinner or use the urinal.

Allegation #2: AP2 abused resident 2 when AP2 made disrespectful comments to resident 2 while providing cares which upset resident 2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive regarding allegation #1. Although a staff member overheard AP1 speaking disrespectfully and refusing to assist resident 1 to toilet or provide other cares the day of the incident, AP1 did not interview, and resident 1 could not recall the incident.

The Minnesota Department of Health determined abuse was inconclusive regarding allegation #2. Two staff members overheard the interaction between AP2 and resident 2. Only one staff member recalled AP2 holding resident 2 up in the lift, refusing to lower him down. AP2 did not interview, and resident 2 denied anything happened, stating staff treated him well.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted family and case managers. The investigation included review of the residents' medical records, the facility's policies including vulnerable adult, grievances, incident reports, and internal investigations. The investigation also included review of AP1 and AP2's personnel records. Also, the investigator observed resident cares including dressing and changing a brief, transferring, assisting to eat, and how staff interacted and spoke with residents.

Resident 1 and resident 2 resided in an assisted living facility.

Resident 1's diagnoses included amyotrophic lateral sclerosis (ALS) (a progressive nervous system disease which causes loss of muscle control). Resident 1's care plan included assistance with dressing, incontinence care, transfers, and eating. Resident 1's assessment identified resident #1 as at risk to be abused and able to report abuse.

Resident 2's diagnoses included stroke and weakness on one side of the body. Resident 2's care plan included assistance with transfers and incontinence care. Resident 2's assessment identified resident 2 as at risk to be abused and able to report abuse.

Allegation 1:
A facility-provided document indicated a manager completed an interview with a staff member. This staff member reported she had been walking by resident 1's room and heard AP1 shame resident 1 for soiling his pants and treated him with disrespect in the way she communicated with him. The staff member heard AP1 refuse to give resident 1 the urinal or put him on the commode and stated from then on, he would need to wear a condom catheter or brief. The staff member stepped in and requested AP1 leave resident 1's room. Later that evening, AP1 declined to assist resident 1 to eat because resident 1 wanted to again use the urinal prior to eating. The staff member took over providing cares for resident 1.

Resident 1's service delivery record indicated the resident received eating assistance, bed mobility, bathing assistance, safety checks, and a skin care check the day of the incident. This service delivery record did not identify which staff members provided these services.

During an interview, a manager stated a staff member reported AP1 saying things to resident 1, making him feel bad for needing help using the urinal. The manager spoke with resident 1 who confirmed some of the statements AP1 had made to him. The manager completed an investigation and spoke with some residents and staff members. Additionally, AP1 did not work

again at the facility and her employment ended. The manager stated this had been the only incident reported to her regarding AP1 and resident 1.

During an interview, unlicensed personnel (ULP) 1 stated AP1 would not give resident 1 the normal amount of food he requested because resident 1 took an abnormal amount of time to eat, around two hours.

During an interview, resident 1 did not recall this incident or anything from the timeframe of the allegation.

During an interview, a family member could not recall many specifics but stated he thought resident 1 and AP1 had a good working relationship until resident 1 soiled himself after not being put on the commode. After the incident, problems started to arise including not receiving showers and thought AP1 did not provide services out of spite.

Allegation 2:
A facility-provided document indicated a manager completed an interview with ULP 1 who reported he overheard AP2 arguing with resident 2 when walking past resident 2's room. ULP 1 recorded it.

Another facility-provided interview indicated the manager completed an interview with resident 2 who reported AP2 had been rude, going into his room, "running her mouth," and calling his mother a derogatory word. Resident 2 did not elaborate further but stated everything had been going well and was happy with the care he received.

During an interview, a manager stated she listened to the recording of the incident. AP2 spoke inappropriately to resident 2, including comments about his mom who had passed away. The manager completed an internal investigation and spoke with resident 2 who did take offense to the things AP2 said. Resident 2 also told the manager AP2 had spoken to him like that previously but did not go into detail when asked. AP2 did not work at the facility again after the incident occurred.

During an interview, ULP 1 stated resident 2 needed assistance with changing his brief. ULP 1 and ULP 2 were in the kitchen when they started to hear laughing and yelling. At first, they thought it was positive in nature but quickly realized it was not. ULP 1 recorded the conversation on his phone. AP2 and resident 2 had been goofing around, but then AP2 said something about resident 2's mom. Resident 2 told AP2 not to talk about his mom. AP2 said derogatory and offensive things, insulting resident 2 and his mom. At this point, ULP 1 stepped in, instructed AP2 walk away, completed his brief change, and comforted resident 2.

During an interview, ULP 2 stated during the incident, she heard resident 2 tell AP2 to put him down. AP2 had not properly strapped resident 2 in when she lifted him in his transfer machine, so he had been "hanging in the air." At that point, ULP 2 stepped in and finished caring for

resident 2. Prior to this incident, there had been times AP2 spoke to resident 2 rudely, but this had been the first time ULP 2 felt AP2 may have put resident 2 in danger.

Resident 2 declined to interview, but denied the allegation and stated staff treated him well.

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:
(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:
(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: Resident 1: Yes. Resident 2: No; declined to interview.
Family/Responsible Party interviewed: Resident 1: Yes. Resident 2: Not applicable.
Alleged Perpetrator interviewed: AP1: No. Attempted to contact but did not answer phone for scheduled interviews. AP2: No. Did not respond to subpoena.

Action taken by facility:
The facility completed internal investigations for both incidents. AP1 and AP2 are no longer employed by the facility. Additionally, the facility held education and trainings at staff meetings regarding reporting suspected maltreatment, setting boundaries, and treating residents with dignity.

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
	30445	A. BUILDING: _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(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 29, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL304453225M/#HL304455263C and #HL304456586M/#HL304452429C. No correction orders are issued.	0 000		