Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334365601M
Compliance #: HL334367863C

Date Concluded: November 26, 2024

Name, Address, and County of Licensee Investigated:
The Geneva Suites
6222 Braeburn Circle
Edina, MN, 55439
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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):
The alleged perpetrator (AP), a facility staff member, emotionally abused the resident when the AP used oral and gestured threats of physical violence towards the resident. The resident felt threatened.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was inconclusive. There were conflicting reports of the incident between the resident and the AP and no witnesses to the alleged altercation and the resident provided varied reports of the incident to law enforcement.

The investigator conducted interviews with facility staff members, including administrative staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel file, law enforcement report, and related facility policy and

procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes. The resident's service plan included assistance with bathing, dressing, bed mobility, behavior management including agitation and verbal aggression. The resident had a history of raising his voice and using profanity directed at staff when the resident felt staff were not meeting his needs. During those times, staff were directed to ensure the resident's needs were met, redirect the resident's behavior, and notify leadership immediately. The resident used an electric wheelchair independently, was alert, oriented, able to communicate, make his needs known, and independently used a mobile phone.

Records indicated one day, the resident reported a different resident's call light had repeatedly went off, prompting the resident to go the dining room to search for staff. The resident asked the AP and another staff member to investigate the other resident's call light issue. The resident said to the AP "Can one of you do your job?" In response, the AP, in a "rude manner" with a raised voice, told the resident to "shut up and go to your room," and then stood over the resident in an "intimidating way." The resident went to his room with the AP following him, and the AP "slammed the door to the room so forcefully the door frame was damaged." The resident felt threatened and called 911. The AP went outside of the facility and tapped on the resident's window, questioning the resident as to why the resident called the police. The police arrived, spoke with everyone involved, and left.

The resident records indicated the resident was agitated and verbally aggressive during the shift and called law enforcement. The resident was "yelling," "cursing," and used "ratial [sic] slures [sic]" towards staff and threatened to "shoot staff dead." The resident had been drinking alcohol for hours before the behaviors occurred. After the police came, the resident "calmed down" and stayed in his room the remainder of the night.

The law enforcement report indicated the resident called 911 to report the AP threatened the resident he would be kicked out of the facility because the resident was intoxicated. The resident stated he became upset waiting for 30 minutes after pressing a call pendent for staff to respond so the resident left his room to confront the staff. The AP and resident got into a verbal altercation, nothing physical. During the verbal altercation, the AP closed the resident's door hard enough to break a piece of framing. Law enforcement told the AP not to take out frustration on residents. The report also indicated the resident was upset because staff failed to prepare his meal according to the resident's request. Both the AP and resident agreed to be civil the remainder of the evening.

During an interview, the resident stated there was an occasion when a staff member (AP) made him feel scared and fearful. The AP was not doing his job. A different resident kept using their call pendent needing assistance. The resident found staff and told the staff to do their job. The AP followed behind the resident to the resident's room, "yelled" at the resident saying, "get to

your room, get to your room" and "yelled" at the resident to "stay in his room." The resident said he felt the AP wanted to fight, punch, or shoot him. The AP "slammed" his room door and broke the "door handle" and "door frame." The resident said the incident made the resident uncomfortable and concerned for his personal safety, and the resident called 911. The resident said this was the only time this type of incident had occurred and said there had been no similar incidents since.

During an interview, the AP stated the resident was intoxicated from alcohol the evening of the incident. The resident used racial slurs towards the AP and told the AP he was going to "shoot" him. The AP said he asked the resident to be respectful. The AP said he did not say anything or act in a way where the resident could have felt scared, fearful, or threatened. The AP said he was providing care for another resident when the resident wanted the AP's assistance, and the AP was not able to respond to the resident's call light right away. The AP stated the resident wanted his food plate removed and/or wanted another beer and it was not an emergency. The AP said he told the resident he would get to him as soon as he was done assisting the other resident. The AP said he told the resident "please go to your room." The AP denied standing over the resident in an intimidating way. Also, the AP said his intention was not to "slam" the resident's door, he was frustrated as it was late in the shift and staff were still assisting all the residents to bed. The AP said he was not frustrated with the resident. When the room door shut, a piece of the door broke off. The AP stated law enforcement was called, and law enforcement asked them to get through the remainder of the shift. The AP denied tapping on the outside of the resident's window after the resident called law enforcement.

During an interview, leadership stated the resident reported he felt afraid and fearful the day of the incident. The resident said when the AP aggressively yelled at him, the resident went to his room. Leadership stated the AP followed behind the resident and shut the resident's door hard enough to cause damage. Leadership stated the AP had worked with the resident before and there were no prior incidents reported by staff related to interactions between the AP and the resident. Leadership said the facility had received praise from resident families regarding the AP. The other staff who worked that evening said they did not witness interaction between the AP and resident.

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:

(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: Yes.
Family/Responsible Party interviewed: No. Responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and re-educated staff on how to deal with agitated residents and how interact with residents respectfully. The AP is no longer employed by the facility.

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
	33436	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6222 BRAEBURN CIRCLE EDINA, MN 55439

(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 October 14, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL334367863C/#HL334365601M. No correction orders are issued.	0 000		