Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346223428M
Compliance #: HL346223633C

Date Concluded: July 29, 2024

Name, Address, and County of Licensee Investigated:
Sisters Assistant Living Care
1129 County Road B2 West
Roseville, MN 55113
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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) abused the resident when he pulled the resident by the hair and placed her in a physical hold as a restraint.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting reports of what occurred. The resident stated the AP grabbed her by the hair and forced her into her bedroom. The AP stated the resident's behavior was a safety risk for herself and others, so the AP held onto the resident's shirt sleeves and guided the resident into her room. The AP stated he did not grab the resident's hair or restrain the resident in anyway.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and a case worker. The investigation included review of the resident record, facility incident reports, personnel files,

staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included mental retardation. The resident's services included assistance with socialization, behavior management, meals, and medication management. The resident's assessment indicated staff were to redirect the resident in a calm and respectful way, remove triggers if able, and review all possible options to prevent episodes of agitation from escalating.

The resident's progress notes indicated the resident became agitated when she asked staff to close the window in the office and facility staff did not close the window. The resident's behavior became "aggressive" and "uncontrollable." The resident screamed at staff, threw chairs, and attempted to engage in a physical altercation with another resident before staff intervened. Staff used "appropriate physical" [sic] and "removed resident from living room into her room."

When interviewed, the resident stated she wanted the office window closed. The resident said she was having "my bad behavior," and the AP grabbed her by the hair, at the back of her head, and brought her back to her room. The resident said it hurt when the AP grabbed her by the hair, and he sat her in her chair "really hard." The resident said she stayed in her room until she calmed down.

When interviewed, the AP stated the resident became agitated because she wanted the office window closed. The AP wanted the window open and declined to close it. The resident's agitation escalated to the point where the AP said redirection was ineffective. The resident began to throw dining room chairs, display violent, threatening behavior, and kicked walls. The AP stated he needed to ensure the safety of staff and other residents, so the AP stated he took the resident by the shirtsleeves of both arms and physically escorted the resident to her room.

When interviewed, a family member expressed concern about communication from the facility, staff education, and the resident's behaviors, and socialization.

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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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
	34622	A. BUILDING: _____ B. WING _____	C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTERS ASSISTANT LIVING CARE	1129 COUNTY ROAD B2 WEST 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 On June 14, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL346223633C/#HL346223428M. No correction orders are issued.	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.	