Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366014584M
Compliance #: HL366017915C

Date Concluded: March 13, 2023

Name, Address, and County of Licensee Investigated:
Suite Living of Ramsey
7007 139th Lane Northwest
Ramsey, MN 55303
Anoka County

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

Evaluator's Name:
Katie Germann, RN, 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), facility staff, abused a resident when she forced the resident to take medications. In addition, the AP restrained the resident to prevent the resident from getting out of bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was observed on camera forcing a spoon with medications into the resident's mouth. In addition, the AP was observed on video restraining the resident when she elevated the foot of the resident's bed for approximately 2 hours, preventing the resident from getting out of bed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, policies

and procedures, employee files, training records, and video footage of the incident. In addition, the investigator observed facility staff and resident interactions and medication administration.

The resident resided in an assisted living memory care unit with diagnoses including Dementia. The resident's service plan included assistance with activities of daily living, transfers, bathing, meals, housekeeping, and laundry. The resident had cognitive impairments due to end stage dementia that caused him to have difficulty with verbal communication. The resident was also at risk for chocking and had a pureed diet with nectar thick liquids.

The Video footage of the incident was reviewed, and the AP was observed entering the resident's room with a cup which appeared to be pudding and a spoon. While the resident was lying flat in bed, the AP dipped the spoon into the pudding and attempted to put it in the resident's mouth. The AP stated to the resident, "Here is your medication". The resident put his left hand in front of his face. The AP continued to attempt to give the resident the medication by repeating to the resident, "Here is your medication" and attempting to open the resident's mouth by saying, "ahh, ahh", and placing the spoon on the residents' lips. The resident continued to refuse and swatted at the spoon again. The AP stated, "You need your medication, okay?" The AP stood silently over the resident with the spoon in her hand for approximately 40 seconds, while the resident looked up at the AP as he attempted to sit up in bed but was unable. The AP stated to the resident, "This is ice cream, do you want ice cream?" The resident continued to attempt to sit up in his bed, swung his legs over the side of the bed, and the AP continued to stand over the resident and tell him to eat his ice cream. The AP set the spoon down, grabbed the resident beneath his arms and boosted him up in the bed, and put the residents' legs back in the bed. The AP picked up the spoon again and stated to the resident, "Don't fight me, you need to take your medication". After several more unsuccessful attempts to convince the resident to take his medication, the AP left the spoon and the pudding cup on top of the resident's nightstand and left the room.

Approximately 4 ½ hours later the AP was observed on video re-entering the resident's room. The resident was calmly lying-in bed with the covers off. Without saying anything the AP approached the resident and grabbed onto the resident's brief appearing to see if it was soiled. The resident started to attempt to sit up in bed and the AP pushed on the residents back attempting to roll the resident to his right side. After changing the residents brief, the AP again attempted to administer the residents' medications which were still on the nightstand in the pudding from 4 ½ hours prior. The AP held both of the residents' hands down with her left hand and forced the spoon with the pudding/ medications into the resident's mouth. The resident began to cough and attempted to get out of bed. The AP again restrained the residents' hands and stated, "Let me wipe your mouth", as she wiped the resident's mouth with a wet cloth. The AP left the room for approximately one minute before returning back to the resident's room. The AP elevated the foot of the resident's bed and the residents' legs were elevated higher than his head. The AP left the resident with the legs of the bed elevated, and the resident was observed on video attempting to sit up in bed but was unable to lift his upper body. The AP was observed entering the residents room minutes before shift change and lowered the foot of the residents' bed. The AP left the resident in bed with his legs elevated for over 2 hours.

During interview facility management stated the recorded video was shown to her by the resident's family member. The management stated the AP was observed forcing medications into the resident's mouth and was also observed elevating the foot of the resident's bed until the end of the AP's shift, which was over 2 hours.

When interviewed the AP stated the resident's mouth was open so she didn't feel she forced the resident to take the medications. The AP stated the resident was pushing the spoon away but she wanted to ensure the resident received his anti- anxiety medication so he would be calm and sleep. The AP stated she elevated the foot of the resident's bed prior to leaving the room so the resident wouldn't get out of bed. The AP stated the resident often attempted to get out of bed and she was unable to watch the resident because she had to provide care for other residents.

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;

Vulnerable Adult interviewed: Unable.
Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed re-education of all staff regarding vulnerable adult incidents and dementia care. The AP is no longer employed at the facility.

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

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
Anoka County Attorney
Ramsey City Attorney
Ramsey Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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 LICENSING 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: #HL366017915C/#HL366014584M On February 7, 2023, 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 24 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #H366017915C/#HL366014584M, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one resident (R1) reviewed was free from maltreatment. R1 was abused Findings include: On February 7, 2023, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	