Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368939708M
Compliance #: HL368937802C

Date Concluded: February 5, 2024

Name, Address, and County of Licensee Investigated:
Premium Health Care Inc.
7532 13th Avenue South
Minneapolis, MN 55423
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 facility neglected the resident when they failed to supervise resident #2 who had unwanted sexual contact with resident #1.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Resident #1 stated resident #2 tried to have sexual contact with her, however, resident #2 stated the incident did not happen. There were no witnesses or additional evidence to support the allegation. Neither resident had a history similar reports/behavior.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and spoke with law enforcement. The investigation included review of the residents' records, facility incident reports, facility policy and procedures related to supervision of residents, staffing, and

maltreatment of vulnerable adults. Also, the investigator observed staff monitoring of residents.

Resident #1 lived in an assisted living facility. Resident #1's diagnoses included organic personality syndrome. Resident #1's service plan included assistance with housekeeping, laundry, behavior management, meals, medications, and safety checks. Resident #1's assessment indicated resident #1 experienced anxiety.

Resident #2 lived in the assisted living facility due to diagnoses that included dementia and schizophrenia. Resident #2's service plan included assistance with dressing, meals, hygiene, grooming, behavior management, medication administration, and communication with the guardian. Resident #2's assessment indicated he had a history of elopement, paranoia, and impaired decision making.

An incident report indicated one evening resident #1 yelled out to staff, who saw resident #2 leave resident #1's room. The report indicated resident #1 stated resident #2 pushed resident #1 onto her bed, kissed her neck, grabbed her breast, so resident #1 yelled out for staff help. The report indicated resident #2 left the room when resident #1 yelled. The report indicated staff notified the nurse.

During an interview, the nurse stated they increased staff rounds to include having eyes on all residents every 15 minutes. The nurse indicated they also placed an additional surveillance camera in the common area outside of resident #1's room and increased activities so residents had less idle time. The nurse stated resident #2 had no history of unwanted touching of others and usually avoided interacting with other residents. The nurse stated resident #2 denied having touched resident #1 in any way. The nurse stated resident #1 did not want to call police.

During interviews, multiple staff stated resident #2 kept mostly to his room and rarely talked to peers.

During an interview resident #1 stated she was surprised when resident #2 tried to kiss her, but when he told her "Shhh" she got frightened and yelled out for staff. Resident #1 stated she thought resident #2 misinterpreted her kindness toward him. Resident #1 stated she did not want to press charges, because she felt the incident was due to resident #2's illness.

During an interview, a family member stated resident #2 told her he never touched resident #1.

During an interview, a law enforcement officer stated a report was filed, investigative interviews were conducted, and law enforcement closed the case with no charges.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Resident #1-yes, Resident #2-No, per guardian.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility implemented 15-minute visual rounds of all residents, installed an additional surveillance camera, updated both residents’ vulnerability plans and service plans, encouraged resident #1 to lock her door when in her room, and facilitated mental health appointments for resident #1 and resident #2.

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
Richfield Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36893	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HEALTH CARE INC	7532 13TH AVENUE SOUTH MINNEAPOLIS, MN 55423

(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 January 18, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL368937802C/#HL368939708M. No correction orders are issued.	0 000		