Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL388604122M
Compliance #: HL388604783C

Date Concluded: November 25, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Crystal
3501 Douglas Drive North
Crystal, MN 55422
Hennepin County

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

Evaluator's Name:
Maerin Renee, 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):
AP1 and AP2 emotionally abused the resident when they repeatedly ridiculed him, shamed him, and spoke to him in a disparaging manner when the resident requested assistance. As a result, the resident's mental health declined.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. AP1 and AP2 were responsible for the maltreatment. Recorded video showed AP1 and AP2 continually harassing the resident using disparaging, derogatory, and humiliating treatment of the resident while providing cares. In one instance, the resident was reduced to tears and was not toileted as he requested.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a resident representative. The investigation included review of camera footage, the resident records, facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included right-sided paralysis, generalized muscle weakness, and aphasia. The resident's services included total cares with activities of daily living, medication management, laundry, and housekeeping. The resident's assessment indicated he was wheelchair-bound and required assist of two using a standing lift for transfers and toileting.

The recorded video of the resident's room for the two days of the incidents was reviewed and the following was observed on the first day:

AP1 scolded the resident and accused him of trying to get staff in trouble by telling the nurse he pushed his pendant when he did not do so. The resident attempted to say he did push his pendant, but AP1 interrupted and told him he did not. AP1 threatened the resident and told him she was going to document the resident was displaying "behaviors."

Later that day, AP2 set up the resident's dinner in his room and asked the resident if he wanted ice in his beverage. Before the resident could answer, AP1 said, "No, he doesn't need ice." The resident looked at AP1 and asked her to leave his room and AP1 refused. The resident asked AP1 several more times to leave his room, and she responded to the resident with sarcastic comments while refusing to leave his room. As AP2 finished setting up the resident's meal, AP1 stepped close to the resident's face and laughed at him. AP1 said she would be back with his medications and said to the resident in a mocking tone, "Don't make a mess on yourself!"

Later that evening, AP2 attempted to help the resident transfer using the standing lift. AP2 spoke to the resident in a tone of annoyance as he relayed instructions. The resident's phone rang, and the resident attempted to answer it before AP2 grabbed the phone and either turned off the ringer or hung up the call. The resident reached for his phone and AP2 yelled, "[Resident's name], it's 9:59!" AP1 entered the room and AP2 said the standing lift was not working. AP2 and the resident continued to argue back and forth and AP2 yelled, "I can't help you when you're talking on the phone!" AP2 continued to yell as the resident continued to request help to the bathroom. AP1 said, "No, at this point, no." A third staff member entered the room and said they were instructed to use the mechanical lift if the standing lift was not working, and then left. AP2 said the resident had refused the mechanical lift. [There was no indication in the camera footage that the resident refused the mechanical lift]. The resident said it was AP2 who would not use the mechanical lift. AP2 said, "…what do you mean we won't use it? You told us to put you back down." AP2 continued to insist the resident refused to use the mechanical lift and argued with the resident, who began to cry. AP1 said, "Oh my god, come on! " The resident's phone rang again, and he answered. The resident cried as he talked to his representative and told them staff would not take him to the bathroom. The representative asked to talk to a staff member. AP2 told the representative he would call the representative from the nurse's station. The representative agreed but wanted to talk with the resident a little

longer. The resident continued to cry as he talked with his representative, and it was difficult for him to get words out due to his aphasia. AP1 and AP2 did not return to help the resident with toileting.

The recorded video of the resident's room was reviewed, and the following was observed on the second day:

The resident was sitting in his recliner and AP2 entered the room. AP2 said, "I told you we was gonna come and help you. You're gonna go on a bedpan, you know that, right?" The resident said he wanted to use the standing lift. AP2 told the resident he goes on a bedpan, and he didn't go into the bathroom anymore. The resident said something unintelligible and AP2 yelled, "I helped you on Friday!" The resident responded something, and the AP yelled at the resident she was going to check his care plan and come back. Shortly after, AP2 re-entered the room with AP1. AP1 showed the resident a piece of paper and said in a condescending tone, "So…on here, which is your care plan, it says right here that you [unintelligible]." The resident told AP1 he wanted to go to the bathroom and AP1 handed the resident the care plan and asked if he wanted to keep a copy. AP1 sarcastically stated, "It's highlighted in bold for you, alright? Have a good night. Do you need anything else?" The resident said no and AP1 and AP2 left the room, laughing gleefully outside the door. The resident looked into the camera and said, "See what I mean? They're laughing outside." The resident attempted to read the care plan, but apparently had difficulty comprehending it. Neither AP1 nor AP2 returned to help the resident with toileting as he had requested.

The resident's progress notes indicated a facility nurse told the resident's representative the resident could not bear weight long enough to use his standing lift for transfers. The facility nurse requested a physical therapy (PT) evaluation and said until then the resident needed to use a mechanical lift and bedpan for toileting. The resident was not in agreement with that plan and three weeks later, PT orders indicated the resident was safe to use the standing lift for toileting and transfers. Three days later the resident requested help with toileting, but staff said the standing lift battery was not charged, so the nurse on duty advised staff to use the mechanical lift and a bedpan. Two days after that, the resident's representative questioned the resident's toileting/transferring orders. The nurse read the care plan to the resident's representative, who informed the nurse that PT had updated the orders. The nurse requested the resident's representative call back during the week, because she did not have access to the resident's paper chart.

A PT note indicated the resident had been cleared for use of his standing lift for transfers and toileting. The resident's service plan indicated staff were to use the resident's standing lift for help with transfers. The resident's care plan indicated two staff were to help the resident with transfers and toileting using his standing lift. The resident's care sheets indicated he was to be assisted by two staff members for toileting, and the resident was to be transferred via his standing lift. Both AP1 and AP2 signed off on the care sheets as having assisted the resident to the bathroom via the standing lift.

A written statement provided by the resident's representative indicated, "As an overall summary of the following videos taken from the…camera…I see behavior by two staff members…that can only be described as impatient, provoking and taunting, bickering and argumentative, accusatory and escalatory, shaming and retaliatory. Their actions and attitude create fear, anxiety and frustration…and incites him to react and then [the resident] ends up being reported and labeled as a troublemaker…There is a sore lack of compassion and de-escalation skills and they clearly do not have the temperament or training for the job…"

AP1's personnel file indicated she received a written warning indicated she needed improvement to conduct herself in a professional manner in both action and speech with co-workers, families, and supervisors. A 30-day review indicated AP1's "performance needs improvement" in "communication/rapport."

AP2's personnel file indicated he received a verbal warning regarding a complaint of being rude to a resident. AP2 stated he would be more mindful of his tone in the future. Other performance reviews involved not following protocols, medication errors, and problems with attendance.

When interviewed, multiple staff leaders stated they watched the videos and described what they saw as heartbreaking and unacceptable. They described the behavior of AP1 and AP2 as belittling and mocking, AP1 and AP2 did not take the resident seriously, and repeatedly walked out of the room when the resident was talking. After AP1 and AP2 no longer worked at the facility the resident's overall demeanor improved.

When interviewed, AP1 stated she was empathetic and went above and beyond to help residents. AP1 said she would never be verbally disrespectful to anyone in the elder community.

When interviewed, AP2 said he never raised his voice to the resident, but he did speak more clearly in a way the resident could understand. AP2 said crying was a tactic the resident used to gain sympathy.

When interviewed, the resident said he didn't talk very well, and AP1 and AP2 were very rude. The resident felt like they did not care about him or the job they were doing, and that was not the way to talk to him or other residents. The resident said since AP1 and AP2 left the facility he felt fine.

When interviewed, the resident's representative said the resident had a stroke and sustained right-sided paralysis and aphasia (difficulty speaking). The resident was wheelchair-bound and required total cares. The representative said several months after the resident moved to the facility leadership brought up concerns regarding the resident's behavior. They described the resident as having anger issues which, to the representative, seemed out of character and hard to believe. After a camera was placed in the resident's room, the representative reviewed

camera footage and saw AP1 and AP2 treating the resident in an argumentative and scolding manner and described AP1 and AP2 as “playing games” with the resident. AP1 and AP2 continually taunted and berated the resident. When the representative spoke to AP2 about the confusion between using the standing lift as opposed to the mechanical lift, AP2 became argumentative and then abruptly hung up the telephone. The representative shared the camera clips with facility leadership and scheduled a meeting. Facility leadership reviewed the video clips and agreed what they saw in the footage should never have happened and AP1 and AP2 were let go.

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: …
(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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility updated the resident’s care plan. AP1 and AP2 no longer work 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
Hennepin) County Attorney
Crystal City Attorney
Crystal Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38860	A. BUILDING: _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF CRYSTAL LL(	3501 DOUGLAS DRIVE MINNEAPOLIS, MN 55442

(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 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: #HL388604783C/#HL388604122M #HL388604237C/#HL388603783M On October 4, 2024, 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 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL388604783C/#HL388604122M, tag identification 0620, and 2360.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report an incident of suspected abuse to the Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for one of one resident, R2, reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include:	0 620		

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0 620	Continued From page 3 R2's diagnoses included right-sided hemiplegia, generalized muscle weakness, and aphasia. R2's service plan dated October 24, 2023, included assistance with activities of daily living, medication management, housekeeping, laundry, and meals. The resident was an assist of two staff using an EZ stand for transfers and toileting. During interview on October 4, 2024, the regional director of nursing (RN)-A stated she and other staff leaders reviewed video clips provided by R2's power of attorney (POA)-H in which two staff members, (ULP)-I and (ULP)-J, were witnessed emotionally abusing R2 during their shifts on June 7, 2024, and June 8, 2024. RN-A said facility leadership knew POA-H was going to call in a MAARC report, so the facility did not call in a report due to it being redundant. The facility's policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated July 19, 2021, indicated staff who suspect maltreatment of a resident would contact MAARC and such a report must be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 4 This MN Requirement is not met as evidenced by: The facility failed to ensure one of two resident reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual(s)were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		