Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315733201M
Compliance #: HL315733215C

Date Concluded: July 25, 2024

Name, Address, and County of Licensee Investigated:
Willows of Ramsey Hill
80 North Mackubin Street
St. Paul, MN 55102
Ramsey County

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

Evaluator's Name: Brooke Anderson, 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 unlicensed staff member, abused the resident when the AP slapped the resident on her cheek with the back of her hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information provided, it could not be determined whether the alleged incident did or did not occur. The staff member/alleged perpetrator (AP) denied the allegation, there was a delay in reporting the incident, and there was no camera footage of the alleged incident. In addition, there was no evidence of bruising and/or changes in the resident's mood or behavior following the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospice records, facility internal investigation documentation, facility incident reports,

personnel files, staff schedules, and related facility policies and procedures. At the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit with a diagnosis of dementia. The resident's service plan included assistance with toileting and medication management. The resident's assessment indicated the resident was unable to report abuse or neglect and relied on staff to report signs or evidence of abuse.

An incident report indicated that when the AP and another facility staff member assisted the resident to the toilet, the AP became agitated and slapped the resident in the face with the back of her right hand.

The resident's medical record indicated the AP did not document that they provided services to the resident during the month that the alleged incident occurred. The medical record indicated nursing staff assessed the resident for injuries and no injuries were observed.

During an interview, a facility staff member stated they witnessed the incident. The staff member stated that while assisting the resident in the bathroom, the resident started to fall and when the AP tried to catch the resident, she caught her fingernail on something. The AP then hit the resident in the face with the back of her hand. The staff member heard a slap and the resident said "Ow." When the staff member questioned the AP, the AP stated that her nail got caught. The staff member stated she did not report the incident until one week later because she was in shock.

During an interview, facility management stated after they were informed of the incident, they completed an investigation and suspended the AP. The AP denied the incident and stated that the other staff member was trying to get her fired. Facility management stated that the facility staff member who reported the incident initially stated that she heard a slap, but later reported she saw the slap. The resident was assessed for injury and the AP no longer works at the facility.

During an interview, the resident's family member stated they were informed about the incident and told that the AP was no longer employed by the facility. The family member had no concerns with the care provided at the facility.

Attempts to interview the AP were unsuccessful.

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

Vulnerable Adult interviewed: No, due to cognitive impairment
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, attempts unsuccessful.

Action taken by facility:
The facility conducted an internal investigation and completed education to all staff after the incident. 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
	31573	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102

(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 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL315733215C/#HL315733201M. No correction orders are issued.	0 000		