Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396673461M
Compliance #: HL396673722C

Date Concluded: July 30, 2024

Name, Address, and County of Licensee Investigated:
Grace Assisted Living
7007 Greenbriar Curve
Shakopee, MN 55379
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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 she held the resident down and physically restrained the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident exhibited escalating threatening behaviors that were a danger to the resident and others. When de-escalation techniques were ineffective, the AP brought the resident to a chair and held her arms until law enforcement arrived. The incident does not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, a case worker, and law enforcement. The investigation included review of the resident's records, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, law enforcement

report, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and post-traumatic stress disorder (PTSD). The resident's services included help with meals, medication management, behavior management, instrumental activities of daily living (IADLs), and activities of daily living (ADLs). The resident's assessment indicated the resident experienced agitation with the potential to lead to verbal and physical aggression.

An incident report indicated the resident displayed aggressive behavior toward staff. The resident threw a glass at the AP and hit her. When police arrived, the resident bit a police officer. Police took the resident to the hospital where the resident was assessed in the emergency room (ER).

A police report indicated police arrived and witnessed the resident fighting with staff. A community worker visiting another resident at the facility said the resident threw a cup at the AP's face and hit the community worker's arm. The community worker said the AP was forced to hold the resident in a seated position due to her assaultive behavior. The resident continued to throw things at people and bit a police officer. The police report indicated the resident was a danger to herself and others. Law enforcement restrained the resident to prevent her from biting officers. Paramedics arrived, the resident was placed in a cot and restrained via soft restraints and transported to the hospital.

When interviewed, a community worker who witnessed the incident stated she and another resident entered the facility, and the resident was agitated. The resident yelled and threatened staff members and other residents. As the AP attempted to de-escalate the resident, the resident began to throw things. The resident threw a glass cup at the AP and hit the AP in the face and also picked up a lamp and attempted to hit the AP with it. The AP assisted the resident to a chair further attempting to de-escalate the situation. The community worker stated she called the police, and the resident was transported to the hospital.

When interviewed, a family member stated the resident was new to the facility and demonstrated escalating behaviors due to her confusion and the change in residence. The family member and facility staff worked together to adjust the resident's medication regimen and behavior plan to ease the resident into her new surroundings and decrease her behaviors. The family member expressed satisfaction with the care facility staff provided to the resident.

The AP did not respond to interview requests.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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, unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP did not respond to requests for interview.

Action taken by facility:
The facility continued to work with the resident, her family, and her providers to develop an effective program of behavior management.

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
	39667	A. BUILDING: _____ B. WING _____	C 06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING LLC	7007 GREENBRIAR CURVE SHAKOPEE, MN 55379

(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 26, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396673722C/#HL396673461M. 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.	