Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5148266M
Compliance #: H5148259C

Date Concluded: March 9, 2021

Name, Address, and County of Licensee Investigated:
The Estates at St. Louis Park
3201 Virginia Avenue
St. Louis Park, MN 55426
Hennepin County

Facility Type: Nursing Home

Investigator's Name:
Kathie Siemsen, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An investigator from 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.

Allegation(s):
It is alleged: The alleged perpetrators (AP #1 and AP #2) abused the client when the AP #1 and AP #2 restrained the client to give her a medication.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility was responsible for the maltreatment. Although, AP #1 and AP #2 held the client down to administer an enema rectally after the client refused, the management nurses were aware of the client's ongoing refusal and other nurses required to hold down the client during administration as well.

The investigation included interviews with facility staff, including nursing staff and unlicensed staff. The investigator reviewed policies and procedures related to services, vulnerable adults. The investigation also included, review of the client's medical record, staff schedules and family interviews.

The client's medical record indicated diagnoses included alcoholic cirrhosis of the liver, Wernicke Encephalopathy (brain swelling), depression, altered mental status, failure to thrive and seizures. The client had an alteration in cognition of which interventions included to allow the client time to communicate wants and needs. The client was usually able to make herself understood and was usually able to understand others. The client needed the extensive assistance from staff with activities of daily living (ADL) due to cognitive impairment and being lucid. Interventions included to provide the client with choices and encourage decision making. The client had not had a history of rejecting cares.

The client's medication orders included an order for Lactulose Encephalopathy Solution (a liquid medication used to treat or prevent complications of liver disease of which may help to improve mental status) given orally every 6 hours (three times a day) for liver failure. However, upon return from a hospitalization, the client's lactulose medication was changed to be given rectally through an enema. The medication administration record indicated the client refused the medication from AP #1 the day before the incident.

The incident occurred in the evening. When AP #1 (a registered nurse (RN)) and AP #2 (a RN) approached the client to administer the enema, the client refused the enema. AP #1 and AP #2 then held the client down and administered the enema to the client. AP #1 charted in the medication administration record as the lactulose enema medication was given.

The facility's investigation indicated AP #1, AP #2 and unlicensed personnel (ULP)-D were involved in the incident. AP #1 administered the enema and AP #2 assisted with hold the resident's hands. AP #1 and AP #2 placed a mask on the resident because she yelled and tried to bite them. ULP-D was present in the room and held a bucket during the administration of the enema and assisted AP #1 with cleaning the resident afterwards. AP #1 and AP #2 were removed from working at the facility. Both had received vulnerable adult training prior to the incident.

During an interview with AP #1, she stated she had worked at the facility for 44 years and knew about resident rights. AP #1 stated the resident was in and out of the hospital because she would refuse the lactulose orally. The resident had been back at the facility for a week when AP #1 worked. The resident had orders for lactulose enemas every six hours around the clock. When AP #1 approached the resident with the lactulose enema, AP #1 stated the resident said "no" and started yelling at her. AP #1 stated the resident was traumatized from having enemas all week long. AP #1 did not administer the lactulose enema and documented in the medical record that the resident refused the enema. AP #1 stated she talked to another nurse and was told the nurse manager had tried to change the order to oral because the resident was more alert so the resident could drink it. The next day, AP #1 stated she talked to other nurses and was told they had to hold the resident down to give the lactulose enema. There was also a note at the desk which said the nurse practitioner directed the resident cannot refuse the lactulose enema. AP #1 stated she still was not sure about it because she did not do things against

peoples will. AP #1 felt she had to administer the enema. The resident was alert prior to giving the lactulose enema and she yelled during the enema. AP #1 stated the client was able to express her needs when she was alert. AP #1 stated she explained the procedure to the resident and tried to be gentle.

During an interview with AP #2, she stated AP #1 asked her to assist with the enema. AP #2 stated the client stated she did not want the lactulose enema because she was frustrated and tired of laying in “poop” and waiting for someone to clean her up. AP #2 stated she explained the procedure while trying to distract, reassure the client and held her hands while AP #1 administered the enema. AP #2 denied holding the client’s shoulders and further stated the client was wearing a mask for COVID-19 protection. AP #2 stated she did not feel the procedure was intended to force the client or go against the client’s wishes.

During an interview, ULP-D stated the client stated she did not want to receive the enema, but AP #1 and AP #2 held the client down and gave it anyway. ULP-D stated AP #2 held the client’s arms while AP #1 gave the enema. ULP-D stated she told the nurses to stop and she did not participate in administration. ULP-D was asked why she did not contact the supervisor, the director of nursing (DON) or the administrator. ULP-D stated the supervisor already knew.

During an interview with the DON, he stated he was notified of the incident while the state agency was at the facility investigating another complaint. The DON immediately contacted and suspended AP #1, AP #2 and ULP-D pending the investigation as they were the staff named in the incident. The DON began interviewing other nurses regarding administering the client’s lactulose enema. The nurses reported the client did not like the enemas, needed a lot of coaxing and would eventually consent to receiving the lactulose enema and did not fight them. The DON stated through his investigation it was determined AP #1, AP #2 and ULP-D went too far when AP #2 put a mask on the client because the client was biting and spitting. The DON stated if a client needed a mask put on due to biting and spitting that was clearly an indication to stop. The DON did not feel there was any ill intent. The DON stated the nurses should have documented the lactulose enema as refused and notified the physician.

During an interview, the client’s family member stated she talked to the client once a week or every two of weeks. The client was clear and alert. The client would tell the family member she wanted to go home and hated being at the facility.

At the time of the investigation, the client had since passed away.

In conclusion, abuse was substantiated.

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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
All facility staff was immediately re-educated on the abuse policy and resident rights. In addition, nursing staff was re-educated on medication administration and resident refusals.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.
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:
Health Regulation Division – Licensing and Certification
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
St. Louis Park City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 08/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/13/20 to 8/18/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health. It was determined that your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint H5148259C was substantiated at F600 for past non-compliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. The immediate jeopardy (IJ) began on 7/19/20, when the facility failed to protect R1 from physical abuse. The IJ was identified on 8/18/20, and the director of nursing (DON) and administrator were notified at 1:56 p.m. of an IJ at past non compliance. It was determined that the facility did a thorough investigation, implemented measures to educate staff and showed evidence that the majority of staff had been trained by 8/17/20, therefore, this deficient practice is being cited at Past Noncompliance. AN EXTENDED SURVEY WAS COMPLETED ON 8/18/2020. The following complaint was found to be unsubstantiated: H5148260C Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 600	Free from Abuse and Neglect	F 600		8/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/28/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600 SS=J	Continued From page 1 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to protect 1 of 3 residents (R1) from abuse. Physical abuse occurred when three staff members held R1 down against her will while they administered a medication rectally on 7/19/20, which resulted in an immediate jeopardy (IJ) situation. The IJ began on 7/19/20, when the facility staff failed to protect, prevent, and report a witnessed observation of R1's physical abuse. The IJ was identified on 8/18/20, and the director of nursing (DON) and administrator were notified at 1:56 p.m. of the IJ. The IJ was cited at past non-compliance because the facility had implemented a thorough investigation, facility wide training of staff, and showed evidence of compliance as of 8/17/20. Findings include	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2 R1's diagnoses obtained from the face sheet printed 8/14/20, included alcoholic cirrhosis of the liver, acute respiratory failure, altered mental status and degeneration of nervous system due to alcohol. R1's Minimum Data Set (MDS) dated 6/3/20, indicated R1 had a severely impaired cognition and did not display physical or verbal behaviors towards others. R1's care plan dated 3/25/20, indicated R1 had altered cognition due to alcohol liver failure and needed time to communicate her needs/wants. The care plan directed staff to provide cues, reorientation and supervision as needed. The care plan also indicated on 7/22/20, R1 started to become more lucid, aware, and required assist of one from staff. A review of physician orders revealed R1 had an order dated 7/11/20, for Lactulose Encephalopathy Solution insert 200 gram rectally, via enema, every six hours for liver failure. During further review of R1's July medication administration record, it was revealed R1 had refused the medication from the registered nurse (RN)-A on 7/18/20, at 6 p.m., however, received the medication on 7/19/20, at 6 p.m. from RN-A. A nursing note dated 7/18/20, by RN-A indicated R1 adamantly refused to have lactulose solution given rectally and that risks and benefits were explained, but R1 continued to refuse. During interview on 8/13/20, at 8:43 a.m. nursing assistant (NA)-A identified that an incident involving two nurses and R1 had occurred on the	F 600		

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F 600	Continued From page 3 evening of 7/19/20, where two nurses held R1 down while they administered R1's enema. NA-A then indicated that RN-A had approached R1 to administer the enema but R1 refused it, but then after a few minutes RN-A returned with RN-B and NA-A, to administer the enema. NA-A further indicated that upon entering the room, R1 again refused the enema. NA-A also indicated R1 was yelling and screaming, and that RN-B held R1's hands, and mouth and while holding her down in bed, RN-A administered the enema. NA-A then indicated the incident was never reported to the facility. NA-A further indicated that the incident was reported when R1 had died and that the incident had occurred a week or two prior to being reported to the State Agency by NA-A, on 7/30/20. On 8/18/20, at 8:13 a.m., during interview, the facility administrator and DON notified surveyor that after learning about the incident from the surveyor on 8/13/20, both RNs and NA were suspended and the SA was notified immediately. The DON indicated phone interviews were conducted with both RNs and NA, where it was learned that the incident happened on 7/19/20. The incident had not been reported to the facility immediately per the Abuse Policy and was not reported to the SA until 7/30/20, by NA-A. The DON also identified that both nurses admitted that the incident, as described by NA-A, had occurred. The DON then indicated that RN-A made a statement that she went to give R1 the medication but R1 refused it, then RN-B and NA-A, came in the room, they put a mask over R1's face because R1 was spitting at them. RN-B then held R1's hands down while RN-A administered the enema. The DON also explained that RN-A was asked why she felt that	F 600		

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F 600	Continued From page 4 RN-A and other staff felt there was such an importance of R1 getting this medication, and RN-A indicated it was in the best interest of R1. The DON then stated "I asked if the order told her [RN-A] to hold her [R1] down and force her, [RN-A] stated no." The DON indicated other nurses were interviewed on the floor where R1 resided at that time, all the nurses indicated R1 would refuse her medication but R1 needed to be re-approached. The DON also indicated the nurse practitioner (NP) was interviewed and asked if the intent of the order was for staff to force R1 into getting the medication and NP indicated the order was never meant to force anything on R1. The DON further identified the NP indicated the order for R1 was changed on 7/11/20, due to R1's unresponsive state to receive the medication rectally, but later the order was changed again on 7/21/20, for staff to either give orally or rectally due to R1 becoming more alert and responsive. On 8/18/20, at 11:35 a.m. during a follow up interview the DON stated, "When the staff involved were interviewed, they all acknowledged they performed a medication administration against R1's will." The DON also stated, "[RN-A] did say 'we made her [R1] do it,' and that [RN-B] said 'we put a mask on her because she was screaming and spitting.'" Although the facility staff failed to report the allegation of resident abuse to facility management on 7/19/20; upon learning of the incident of 8/13/20 when brought to the attention by the surveyor, immediate action took place. The incident was reported immediately to the SA, and RN-A, RN-B, NA-A, were suspended pending investigation. A thorough investigation took place	F 600		

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F 600	Continued From page 5 and the facility was able to verify corrective action had been implemented, including RN-A, RN-B and NA-A being terminated. The facility continued with a plan to educate all staff on the importance of reporting, protecting and preventing abuse, which began 8/13/20, and continued to 8/18/20. In addition, the facility planned to have staff take a competency quiz at a later date regarding the information taught about abuse and reporting. It was determined that the majority of staff had been trained by 8/17/20, and therefore, this deficient practice is being cited at Past Noncompliance. Review of Monarch Health Management policy, "Abuse Prohibition/Vulnerable Adult Plan" revised 7/5/19, indicated that the purpose is to ensure that residents are not subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. The policy further indicated that all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. Also that reporting must occur immediately to a supervisor and that reporting to the state agency must be reported no later than 2 hours after forming the suspicion of abuse.	F 600		