Protecting, Maintaining and Improving the Health of All Minnesotans

Health Regulation Division
Investigative Public Report

Maltreatment Report #: H5187177M **Date Concluded:** December 29, 2021

Texas Terrace A Villa Center
7900 West 28th St
St. Louis Park, MN 55426
Hennepin County

Facility Type: Nursing Home

Evaluator's Name:
Lisa Coil, RN Rapid Response Evaluator

Finding: Not Substantiated

Nature of Visit:
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 perpetrator (AP) abused the resident when the AP used inappropriate language and raised her voice at the resident.

Investigative Findings and Conclusion:
Abuse was not substantiated. Although the AP's language was inappropriate, the investigation did not find evidence the AP used this language repeatedly towards the resident. The investigation did not find evidence the resident was upset.

The investigation included a review of the resident's medical records, facility policies and procedures, and information gathered during an onsite survey conducted by License and Certification. The investigation included an interview with the resident's family member (FM). The investigation included attempts to interview the AP.

The resident's diagnoses included partial paralysis of the left side and dementia. The resident's care plan indicated the resident required total assist for grooming, dressing, all other daily activities.

One day the FM visited the resident and heard the AP yelling at the resident through the door. The FM heard the AP tell the resident “Why do you want to get your ass up? When I first asked you, you refused to get up.” The FM entered the resident’s room and the AP told her to “get the fuck out”. The FM left the room and returned with a licensed practical nurse (LPN). At this point, the AP and LPN began to argue and left the room.

Minnesota Department of Health survey notes indicated a registered nurse (RN) entered the room after the AP and the LPN left to check on the resident. The same document indicated the RN asked if the resident was okay to which the resident said he was fine.

During an interview, the FM stated she heard the AP yelling at someone, entered the resident’s room, and found the AP cursing at the resident with a raised voice. The FM stated she did not see the AP touch the resident. The FM stated she asked the LPN to come in the room and the LPN and the AP began to argue with each other.

The investigation included an attempt to interview the LPN and the RN but was unsuccessful.

The investigation included an attempt to interview the AP, but the AP refused.

The investigation included an attempt to coordinate an interview with the resident but was unsuccessful.

The AP is no longer employed at the facility.

In conclusion, 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 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;

(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
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(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.

Action taken by facility: The facility reviewed its policies and procedures regarding vulnerable adult prevention.

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

Or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
	245187	A. BUILDING _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS AT ST LOUIS PARK, A VILLA CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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F 000	INITIAL COMMENTS On 9/9/21, throught 9/10/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H5187171C (MN76489) with no deficiencies due to action taken byt the facility prior to survey H5187172C (MN75406) with a deficiency cited at F584 H5187174C (MN76542) with a deficiency cited at F7600 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		10/14/21

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

Electronically Signed | 10/02/2021

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 584	Continued From page 1 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain clean bedsheets and linens for 5 of 8 residents (R4, R5, R6, R7, and R8) reviewed for environmental concerns.	F 584	1. R4, R5, R6, R7, and R8 have been provided with clean bed linens and beds have been made. 2. All residents at Texas Terrace a Villa Center have the potential to be affected	

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F 584	Continued From page 2 Findings include: When observed on 9/9/21, at 11:21 a.m. R4 had a silver dollar size stain on her white pillowcase that was yellow in color with reddish flecks. Registered nurse (RN)-A verified the stain on R4's pillow, and stated it was likely "drainage" from a wound on R4's back. RN-A verified pillowcases and bed linens should be changed daily or as needed and stated he had "no idea" the pillowcase was dirty. When observed on 9/9/21, at 11:30 a.m. R5 had a large yellow stain on his white bed sheet measuring approximately 14 inches (in) by 12 in. R5 stated he was not sure what the stain was, but stated he saw bugs flying around his room at night. Nursing assistant (NA)-V verified the stain on R5's bed and stated it was "probably urine" as it was "yellowish" in color. NA-A stated he was not sure how R5's sheets would be stained with urine as R5 was continent. RN-B also verified the stain and stated she didn't know what it could be as R5 was continent of both bowel and bladder. When observed on 9/9/21, at 11:38 a.m. R6 had three dark yellow and light brown stains on a pillow sitting atop an armchair in his room. The stains measured approximately 3 in by 1 in, 2 in by 1 in, and 1 in by 1 in. Additionally, there were 2 stains on R6's bed pillow which measured approximately 2 in by 2 in and 3 in by 3 in, and were dark yellow and light brown in color. At 11:49 a.m. RN-B verified the stains on both pillows, and stated, she did not know what the stains were. RN-B stated she expected the soiled linens to be linens as needed, which could be daily.	F 584	by these practices. Residents are being provided with clean bed linens on bath days and as needed. 3. Nursing staff will be provided with education regarding the provision of clean linen and bed making to residents by 10/14/2021. 4. DON/designee will audit 5 resident rooms per week to ensure bed linens are clean. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 584	Continued From page 3 When observed on 9/9/21, at 11:40 a.m. R7 had a yellow stain on her bedsheet which measured approximately 3 in by 2 in. RN-B verified the stain on the sheets, and stated R7 ate in bed. When observed on 9/9/21, at 11:42 a.m. R8 had a reddish purple which measures approximately 3 in by 1 in inch on his pillowcase. There were several additional droplets on R8's bed sheet. RN-B verified the stain on the sheets, and stated she believed it was grape juice and would get R8's sheets and pillowcase changed. When interviewed on 9/9/21, at 3:15 p.m. the director of nursing (DON) stated changing linens was the responsibility of nursing staff, and linens should be changed on shower days or when visibly soiled. The DON stated this was part of the job duties for nursing assistants and and nurses. A policy regarding clean linens was requested but not provided by the facility.	F 584		
F 600 SS=D	Free from Abuse and Neglect 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	F 600		10/14/21

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F 600	Continued From page 4 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 ensure residents were free from abuse for 1 of 3 residents (R3) reviewed for verbal abuse by staff. Findings include: R3's Face Sheet printed 9/10/21, indicated diagnosis included vascular dementia, and hemiplegia (paralysis) affecting the left side. R3's quarterly Minimum Data Set (MDS) dated 8/3/21, indicated R3 had a moderate cognitive impairment and required assistance with bed mobility, transfers, dressing, and personal hygiene. In addition, the MDS indicated R3 had adequate hearing, clear speech, was able to be understood and could understand others. R3's care plan dated 2/15/18, indicated R3 was at risk for abuse/neglect as a vulnerable adult, and would be free from abuse/neglect. The plan directed staff to be compassionate, and report all allegations of abuse/neglect per facility policy. On 9/9/21, at 10:26 a.m. family member (FM)-A was interviewed. FM-A stated on 9/4/21, around 2:00 p.m. she went to visit R3. FM-A stated R3 was still in bed, and was wearing a gown. FM-A stated she approached registered nurse (RN)-C and asked why R3 was still in bed. RN-C stated R3 had refused to get up earlier in the day. FM-A requested R3 be gotten out of bed and dressed, at which time RN-A asked nursing assistant (NA)-A to help R3 get up. As FM-A opened the	F 600	1. R3 states he feels safe at the facility and has not had any further incidents of abuse or neglect. 2. All residents who reside at Texas Terrace a Villa Center have the potential to be affected by these practices. All residents have been interviewed and all residents reported feeling safe at this facility with no further reports of abuse. The facility has reviewed policies and procedures relating to abuse and neglect, and the policies remain current. 3. Staff from all departments will be re-educated on the abuse policy and reporting and investigating allegations of abuse, neglect, mistreatment, injuries of unknown injury, and misappropriation of resident property by 10/14/2021. 4. NHA/designee will interview 5 random residents per week to ensure residents are free from abuse and neglect. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 600	Continued From page 5	F 600		

door and reentered R3's room, she heard NA-A ask R3, "Are you ready to get the f*** out of bed?" FM-A stated she asked "What?" to NA-A, who replied, "What my a**." FM-A stated she went out of the room and reported NA-A's behavior to RN-D. FM-D stated RN-D went into R3's room and attempted to calm NA-A down, at which time NA-A swore at RN-D. FM-A stated she asked NA-A to stop swearing, however, NA-A continued to swear and approached FM-A who thought NA-A wanted to fight. FM-A stated RN-D stood between FM-A and NA-A, and then NA-A pushed RN-D. FM-A stated she was removed from R3's room by RN-D, however RN-D and NA-A remained in R3's room. FM-A stated she located additional staff who came and assisted NA-A to leave the building. FM-A stated R3 appeared "scared" and "sad," and continued to repeat "yes ma'am, I'm sorry ma'am" to NA-A throughout the altercation. FM-A stated R3 later told her he felt he was to blame for the altercation as he had declined to get up earlier that morning when NA-A had offered.

On 9/9/21, at 1:26 p.m. R3 stated NA-A did not want to get him out of bed that afternoon as he had refused to get up earlier. R3 stated NA-A told him, "F* you" at which time FM-A replied, "What?" R3 stated NA-A continued to swear and it exploded into a big fight. R3 stated he was afraid of NA-A and stated, "I didn't want her to hit me." R3 stated another staff came in to help while FM-A and NA-A swore to each other. R3 stated the altercation exploded into a more than it should have.

On 9/9/21, at 1:51 p.m. NA-A was interviewed. NA-A stated she was frustrated as there were only three staff on the floor that day, and she was

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F 600	Continued From page 6 helping other staff with their work in addition to hers. NA-A stated, "Maybe I am overworked and stressed out." NA-A stated she had tried to help R3, but felt FM-A yelled at her. NA-A stated RN-D had entered the room, yelled at her, and pushed her. NA-A stated RN-C also entered the room and told her to, "Shut up." NA-A stated she assisted R3 with lunch, and FM-A came to visit R3 around 1:00 p.m. NA-A stated the voices of herself, FM-A, and RN-D were "elevated, " but she denied cursing at R3 or FM-A. NA-A stated R3 was upset about the interaction. On 9/9/21, at 3:27 p.m. RN-D was interviewed and stated she was passing medications down the hallway from R3's room when FM-A exited R3's room and approached her. RN-D stated FM-A approached her and told her that NA-A had cursed at her. RN-D stated as she was speaking with FM-A, NA-A exited R3's room and approached them. NA-A stated FM-A had lied to RN-D. FM-A returned to R3's room and NA-A and RN-D followed. RN-D stated NA-A told her she could not tell her what to do. RN-D told NA-A she would help get R3 up, NA-A stated she did not want help, and called FM-A and liar. RN-D stated NA-A then threatened to, "Kick her a**." NA-A pushed RN-D out of C3's room and slammed the door. RN-D stated NA-A threatened FM-A, RN-D reentered the room and removed FM-A, and told NA-A to leave the floor. RN-D stated NA-A yelled in the hallway she would, "F* me up," and told RN-D and FM-A to go back to Africa. RN-D stated NA-A was eventually removed from the floor by leadership. On 9/9/21, at 3:42 p.m. RN-C stated she was the nurse who initially directed NA-A to get R3 up to go outside because his wife and family were	F 600		

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F 600	Continued From page 7	F 600		

there. RN-C stated after she spoke with NA-A, she had gone to feed a resident in a nearby room when she heard "distressed" female voices. RN-C observed FM-A outside R3's room, attempting to get in and heard NA-A and RN-D arguing inside R3's room. RN-C entered the room and NA-A was "freaking out" and yelling that everyone was "haters." RN-C stated NA-A exited R3's room and began "flipping the bird" to RN-C, RN-D, and FM-A. RN-C stated NA-A said she would "f*** up" FM-A. NA-A also made racial comments to RN-C, RN-D, and FM-A. RN-C stated NA-A was "definitely out of control" and was eventually removed from the floor by leadership. RN-C stated the altercation occurred in front of R3 who stated he was fine but seemed "upset to some degree."

The facility document Interview/Statement Record undated, indicated NA-A admitted to raising her voice, giving the finger when leaving the floor, having a problem with anger, and telling FM-A and RN-D to go back to their country when interviewed by the administrator.

The facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 11/28/17, directed verbal abuse included oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance. Examples of verbal abuse include of harm. The policy further indicated abuse includes verbal and mental abuse or anything that causes mental anguish.