Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL28226005M
Compliance #: HL28226006C

Date Concluded: January 31, 2020

Name, Address, and County of Licensee Investigated:
Oak Park Senior Living
13936 Lower 59th Street North
Oak Park Heights, MN 55082
Washington County

Name, Address, and County of Housing with Services location:
Southview Senior Communities
945 Sibley Memorial Highway
St. Paul, MN 55118
Ramsey County

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual 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 perpetrator (AP) abused a client when the AP hit and pushed the client, resulting in bruising and a cut over the client's eye.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The facility had policies and procedures in place for abuse prevention. The facility provided staff training for assisting with agitation and provided supervision of the AP, but the AP disregarded the training during the incident.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and a family member. The investigator observed the licensee's four locked memory care units, staff to client interactions, family to client interactions, and client-to-client interactions.

The client moved into the facility due to diagnoses that included Lewy body dementia. The client received services form the home care provider that included dressing, grooming, hygiene, laundry, medication administration, vital signs monitoring, nursing assessments, and escorts to and from meals.

The client's individual abuse prevention plan indicated the client experienced delusions of capture and being locked up that typically occurred in the afternoon. The plan included use of an as needed (PRN) medication when the client became agitated. The client had no history of striking out at staff. The plan indicated that the client did not have the ability to report abuse or neglect. The plan instructed staff to redirect the client, leave the area, and reproach the client at a later time when the client was agitated.

One evening the client returned from an outing with family and told staff he wanted to eat and be left alone. The client sat alone at a table in the dining area and the AP and another staff sat at another table with one client. The client pressed his 'need assistance' pendant and the AP got up to reset it. The AP walked over to the client, stood in front of him, and the client banged a TV remote on the table several times. The AP reached in to grab the client's pendant, which was hanging around the client's neck and the client pushed away the AP's hand.

The AP stood in the same place and leaned in toward the client. The client reached out and struck the AP in the chest and then in the chin area. The AP grabbed the client's hand, pushed it into the client's chest, and shoved the client in the chair backwards across the floor several feet. The client and the AP exchanged words and the client stood up. The AP stepped back and while still engaging with the client, reached for a phone. The client took one-step forward and hit the AP on the left side of the head with the remote. The AP charged at the client, grabbed one hand, struck the client's face, pushed the client backwards into two chairs, and onto the floor. The client had cuts above, next to, and below his left eye.

The client got himself up and walked into another room. The client was agitated, thought he was locked up, and tried to break out a window. The other staff member called the nurse on call, and the director of nursing called to talk to the AP. Neither staff mentioned the client hit the AP or that the AP hit the client and pushed the client down. Another staff member happened to walk onto the unit, saw the client banging on the window, talked calmly to the client, escorted him to his room, and gave him a PRN to calm down. The AP worked the rest of her shift and went home. Nether the AP or the other staff member made a report of the incident.

The next day the director of nursing heard about the incident from a morning staff, who heard it from another staff. The director of nursing called the residence director to review video of the dining room. The residence director called the police to report an assault.

During a police interview, the other staff member who was in the dining room at the time of the incident told police the client was agitated and she told the AP to leave the client alone. The staff member said that she heard the AP threaten to call the police on the client. The staff member told the police officer that the AP called the client a psycho and threatened to have him put in a strait jacket.

During an interview, the director of nursing said that the AP received training on de-escalation and interacting with agitated clients, but did not stay away from the client, did not try redirecting and reproaching the client.

The staff member who witnessed the incident did not respond to a request for an interview.

The AP did not show up for a scheduled interview.

In conclusion, abuse was substantiated.

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;
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;

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, the AP did not show up for a scheduled interview

Action taken by facility:
The licensee provided face-to-face re-education with all staff on the Maltreatment of a Vulnerable Adult policy, including prevention and reporting. The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
A recommendation was made to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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 651-201-4890 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.

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
Washington County Attorney
Oak Park Heights City Attorney
Oak Park Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On January 16, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL28226006C/#HL28226005M. At the time of the survey, there were #92 clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL28226006C/#HL28226005M, tag identification 325, 805, 2015.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors' 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/RULES. STATE HOME CARE PROVIDER/STATE HHA POC TEXT The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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	Continued From page 1	0 000	out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document	0 325	No Plan of Correction (PoC) required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
0 325	Continued From page 2 review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was abused. Findings include: On January 16, 2020, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	Please refer to the maltreatment public report for details.	
0 805 SS=E	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6. Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report an allegation of abuse to the state agency for one of one clients reviewed (C1), when unlicensed personnel (ULP)-E witnessed ULP-F hit C1 and push him to	0 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
0 805	Continued From page 3 the ground, resulting in cuts on C1's face. ULP-E, ULP-F, and multiple staff who heard about the incident failed to report the incident. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: C1's record was reviewed. C1 moved into the facility on August 2, 2019 due to diagnoses that included Lewy body dementia. C1's service plan dated August 2, 2019 indicated the client received the following services: medication administration, dressing, grooming, hygiene, showers, vital signs monitoring, nursing assessments, escorts to meals, meals, laundry, and housekeeping. Review of Garden Cove West Dining area. (n.d.). video from the night of the incident included the following: C1 sat at the dining room table alone facing away from the camera. ULP-E, ULP-F and an unknown client sat at another table to the left about ten feet away. At 1:00 minute of the video ULP-F got up from the table and walked out of view on the left of the dining room. At 1:27 minutes of the video ULP-F walked around the dining table on C1's left side, and faced C1 who was sitting in a chair alone at the table with his head looking down. At 1:35 minutes C1 hit the table in front of him seven times with an item (later described to be a television remote.) At 1:42 minutes ULP-F reached in toward C1's chest	0 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
0 805	Continued From page 4 area. At 1:44 minutes C1 blocked ULP-F's left hand with his right arm. ULP-F stood in the same position, leaned in toward C1, and at 1:45 C1 reached out and struck ULP-F on the left chest area with a closed fist and again into ULP-F's chin. At 1:48 minutes ULP-F grabbed C1's right wrist with both hands, held it up over C1's head, and then held it against C1's chest while she push C1 backwards in the chair a few feet across the floor. ULP-F appeared to talk to C1 while she moved him. At 1:57 minutes C1 got up and ULP-F stepped back three steps. ULP-F stood facing C1, engaged verbally with C1 several times while nodding her head up and down, and at 2:37 minutes ULP-F moved to her right toward the table and grabbed a phone. At 2:38 minutes C1 took a step toward ULP-F and swung at ULP-F with his right hand (which had the remote in it) hitting ULP-F on the left side of the head. At 2:39 minutes ULP-F charged toward C1, grabbed C1's right arm with her left hand, and grabbed C1's face with her right hand, pushed C1 backwards several feet, into two chairs, and onto the floor. At 2:53 minutes C1 used a chair to get himself off the floor, walked around the right side of the table and into the next room (living room). At 2:57minutes ULP-E walked past the other client and moved the chairs back to the table. At 3:00 minutes ULP-F took off her jacket, grabbed a phone and appeared to dial. At 3:28 minutes ULP-E walked toward C1 in the living room, back to the dining room and appeared to dial her phone. At 3:59 minutes C1 repeatedly swung an item at the window in the living room. At 4:05 minutes ULP-F walked to the right and out of view. While ULP-F stayed in the dining room while on the phone. The video ends at 4:59 minutes. During an interview on January 16, 2020 at 1:47	0 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
0 805	Continued From page 5 p.m. regional director of nursing (RDOC)-A stated she got a call from RN-B on the night of the incident that ULP-E reported C1 hitting a window and so she called the facility. RDOC-A stated neither ULP-E nor ULP-F told her that ULP-F hit C1. RDOC-A stated she heard about the hitting the next morning from ULP-G. During an interview on January 16, 2020 at 2:17 p.m. registered nurse (RN)-B stated she was on call on the night of the incident and received a call at about 8:00 p.m. from ULP-E, who stated C1 was agitated. RN-B stated she suggested ULP-E call a staff from another unit to try to calm C1. RN-B stated ULP-E did not tell her that C1 hit ULP-F or that ULP-F hit C1 and pushed him to the ground. During an interview on January 21, 2020 at 11:59 a.m., ULP-G stated that she heard about the incident the morning after it happened. ULP-G stated she first heard about the incident from a (unnamed) friend who worked on assisted living and then from ULP-E. ULP-G stated she called the supervisor (RDOC-A) to tell her about the incident and that C1 had bruises. ULP-G stated she worked with C1 the morning after the incident and he "was freaked out and would not let anyone touch him, and he told me that he got beat up." During an interview on January 22, 2020 at 3:29 p.m., ULP-H stated that she walked onto the unit on the night of the incident and saw that the staff needed help with C1. ULP-H stated she went to C1, talked calmly to him, escorted him to his room, and gave him an as needed dose (PRN) of medication. ULP-H stated neither ULP-E nor ULP-F told her what had happened and she went back to her own unit.	0 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
0 805	Continued From page 6 ULP-E did not respond to requests for an interview. ULP-F did not show up for a scheduled interview. The Maltreatment of a Vulnerable Adult policy dated January 1, 2019 indicated all staff members are mandated reporters. The policy further indicated that any mandated reporter who witnessed or suspected any form of resident maltreatment must report the incident immediately to the registered nurse or residence director. TIME PERIOD FOR CORRECTION: Seven (7) days	0 805		
02015 SS=E	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (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	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
02015	Continued From page 7 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, 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. (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 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 agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead 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:	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
02015	Continued From page 8 Based on interview and document review the licensee failed to implement their policy to immediately report all suspected allegations of maltreatment for one of one clients reviewed (C1). Unlicensed personnel (ULP)-E witnessed ULP-F hit and push C1 to the floor, resulting in cuts to C1's face. ULP-E, ULP-F, and multiple staff who heard about the incident did not report the incident. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: C1's record was reviewed. C1 moved into the facility on August 2, 2019 due to diagnoses that included Lewy body dementia. C1's service plan dated August 2, 2019 indicated the client received the following services: medication administration, dressing, grooming, hygiene, showers, vital signs monitoring, nursing assessments, escorts to meals, meals, laundry, and housekeeping. Review of Garden Cove West Dining area. (n.d.). video from the night of the incident included the following: C1 sat at the dining room table alone facing away from the camera. ULP-E, ULP-F and an unknown client sat at another table to the left about ten feet away. At 1:00 minute of the video ULP-F got up from the table and walked out of view on the left of the dining room. At 1:27 minutes of the video ULP-F walked around the	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
02015	Continued From page 9 dining table on C1's left side, and faced C1 who was sitting in a chair alone at the table with his head looking down. At 1:35 minutes C1 hit the table in front of him seven times with an item (later described to be a television remote.) At 1:42 minutes ULP-F reached in toward C1's chest area. At 1:44 minutes C1 blocked ULP-F's left hand with his right arm. ULP-F stood in the same position, leaned in toward C1, and at 1:45 C1 reached out and struck ULP-F on the left chest area with a closed fist and again into ULP-F's chin. At 1:48 minutes ULP-F grabbed C1's right wrist with both hands, held it up over C1's head, and then held it against C1's chest while she push C1 backwards in the chair a few feet across the floor. ULP-F appeared to talk to C1 while she moved him. At 1:57 minutes C1 got up and ULP-F stepped back three steps. ULP-F stood facing C1, engaged verbally with C1 several times while nodding her head up and down, and at 2:37 minutes ULP-F moved to her right toward the table and grabbed a phone. At 2:38 minutes C1 took a step toward ULP-F and swung at ULP-F with his right hand (which had the remote in it) hitting ULP-F on the left side of the head. At 2:39 minutes ULP-F charged toward C1, grabbed C1's right arm with her left hand, and grabbed C1's face with her right hand, pushed C1 backwards several feet, into two chairs, and onto the floor. At 2:53 minutes C1 used a chair to get himself off the floor, walked around the right side of the table and into the next room (living room). At 2:57minutes ULP-E walked past the other client and moved the chairs back to the table. At 3:00 minutes ULP-F took off her jacket, grabbed a phone and appeared to dial. At 3:28 minutes ULP-E walked toward C1 in the living room, back to the dining room and appeared to dial her phone. At 3:59 minutes C1 repeatedly swung an item at the window in the living room. At 4:05	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
02015	Continued From page 10 minutes ULP-F walked to the right and out of view. While ULP-F stayed in the dining room while on the phone. The video ends at 4:59 minutes. During an interview on January 16, 2020 at 1:47 p.m. regional director of nursing (RDOC)-A stated she got a call from RN-B on the night of the incident that ULP-E reported C1 hitting a window and so she called the facility. RDOC-A stated neither ULP-E nor ULP-F told her that ULP-F hit C1. RDOC-A stated she heard about the hitting the next morning from ULP-G. During an interview on January 16, 2020 at 2:17 p.m. registered nurse (RN)-B stated she was on call on the night of the incident and received a call at about 8:00 p.m. from ULP-E, who stated C1 was agitated. RN-B stated she suggested ULP-E call a staff from another unit to try to calm C1. RN-B stated ULP-E did not tell her that C1 hit ULP-F or that ULP-F hit C1 and pushed him to the ground. During an interview on January 21, 2020 at 11:59 a.m., ULP-G stated that she heard about the incident the morning after it happened. ULP-G stated she first heard about the incident from a (unnamed) friend who worked on assisted living and then from ULP-E. ULP-G stated she called the supervisor (RDOC-A) to tell her about the incident and that C1 had bruises. ULP-G stated she worked with C1 the morning after the incident and he "was freaked out and would not let anyone touch him, and he told me that he got beat up." During an interview on January 22, 2020 at 3:29 p.m., ULP-H stated that she walked onto the unit on the night of the incident and saw that the staff needed help with C1. ULP-H stated she went to	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28226	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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
02015	Continued From page 11 C1, talked calmly to him, escorted him to his room, and gave him an as needed dose (PRN) of medication. ULP-H stated neither ULP-E nor ULP-F told her what had happened and she went back to her own unit. ULP-E did not respond to requests for an interview. ULP-F did not show up for a scheduled interview. The Maltreatment of a Vulnerable Adult policy dated January 1, 2019 indicated all staff members are mandated reporters. The policy further indicated that any mandated reporter who witnesses or suspects any form of resident maltreatment must report the incident immediately to the registered nurse or residence director.	02015		