Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282272547M
Compliance #: HL282274440C

Date Concluded: November 21, 2022

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

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility responsibility

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.

Initial Investigation Allegation(s):
The facility abused a resident when staff held him down to administer medications. In addition, the facility neglected a resident when staff failed to ensure hourly checks were done which resulted in a resident lying on the floor for an extended period.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. There was no evidence to support staff held the resident down to administer medications.

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Video footage captured the resident's fall and showed him lying on the floor for approximately four hours. The resident's service plan indicated staff were supposed to provide hourly safety checks.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of resident records, employee files, incident reports, video footage, and facility policies. The investigator toured the facility and observed interactions between residents and facility staff. Also, the investigator observed medication set up and administration.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included Parkinson's disease, dementia, agitation, delirium, and hallucinations. The resident's service plan included assistance with bathing, dressing, grooming, toileting, hygiene, feeding, housekeeping, and medication administration. The service plan indicated the resident required hourly safety checks. The resident's nursing assessment indicated he had intermittent confusion and difficulty with word finding. The resident's vulnerability assessment indicated the resident was unsteady when walking and fell frequently.

During an interview, a family member said a female staff member grabbed both the resident's wrists and held him down while she administered medication. The family member said there was video footage of the incident. The family member said they brought video footage to leadership.

During an interview, the manager said a family member brought her video footage of a male staff member administering medication. The manager said she watched the video, with the family member, and observed a male staff attempting to administer medication to the resident for over one hour. The manager said the staff member was observed sitting with the resident. The manager said the staff member appeared to be calm and patient. The manager said the family member reported the video footage would show the male staff member hold the resident down. The manager said the video footage ended, and the family member did not bring further video footage. The manager said she did not observe any video footage of staff holding down the resident.

During investigative interviews, multiple leadership staff members denied observing video footage of any staff holding the resident down.

The investigator reviewed video footage provided regarding medication administration. The resident was observed in his room, while a female staff member prepared medication. The video footage ended after medication was prepared but did not capture the medication administration. The video footage resumed and showed a female staff member wiping the residents face. Video footage did not show the resident being held down by staff.

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

During an interview, a family member said they observed video footage of the resident falling. The family member said they went to the facility and observed the resident lying on the floor.

The family member said the staff could not have checked on him because his legs were at the door. The family member said the resident was not injured, but hourly checks should have been provided.

The investigator reviewed video footage provided regarding the resident's fall. The resident fell from the kitchen area toward the bathroom area. Video footage captured sound and movement that provided a timeline of the incident. According to video footage, the resident fell and laid on the floor for approximately four hours unattended by staff, from 11:10 p.m. until 3:05 a.m. when the family member arrived.

The residents service plan indicated staff would provide hourly checks. The plan indicated the resident was at risk for falls and had fallen multiple times.

The resident's treatment administration record falsely indicated safety checks were completed throughout the night at 12:00 a.m., 1:00 a.m., 2:00 a.m. and 3:00 a.m. The record indicated agency staff provided documentation.

During an interview, the manager said facility staff should have provided education to agency staff before they left that evening. The manager said there was no incident report regarding the resident's fall. The manager said they were unsure if facility staff gave a verbal report to agency staff before they left. The manager said a family member went to the facility and alerted agency staff the resident had fallen.

The investigator reviewed facility email documentation regarding the fall. The documentation indicated there was confusion from the agency staff about services the resident required.

During investigative interviews, multiple leadership staff members said the resident should have had hourly checks.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

"Substantiated" means:
a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;
(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.
(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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, due to advanced disease.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility provided education to staff.

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. 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
The Office of Ombudsman for Mental Health and Developmental Disabilities
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
	28227	A. BUILDING: _____ B. WING _____	C 10/06/2022

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: #HL282274440C/#HL282272547M On October 6, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were one hundred nineteen residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL282274440C /#HL282272547M, tag identification 630, 1640, 2360.	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 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 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 §144G.30, Subd. 5 (c), the assisted living facilities 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. § 144G.31, Subd. 2 and 3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one (R1) of three records reviewed. 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 received services for diagnoses that included Parkinson's disease, dementia, and agitation. R1's medical provider notes dated August 9, 2022, indicated R1 had obsessive compulsive behaviors, wandering, and agitation. The notes indicated R1's behaviors were significant. The notes indicated R1 required Seroquel	0 630		

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0 630	Continued From page 2 (anti-psychotic) medication. The notes indicated R1 was impulsive. The notes indicated R1 was resistive with medication administration. R1's hospice orders dated April 13, 2022, indicated delirium and hallucinations were to be added to R1's diagnosis list. R1's medical record indicated Seroquel dosages were increased three times during August 2022, because of agitation, delirium, and restlessness. During an interview on October 10, 2022, at 1:30 p.m., registered nurse (RN)-E said R1 resisted medications. RN-E said R1 would push staff away. RN-E said she observed video footage of staff attempting to administer medication to R1 for over an hour. R1's vulnerability assessment dated August 26, 2022, failed to identify diagnoses of delirium, hallucinations, and agitation. The assessment failed to identify obsessive compulsive behaviors, restlessness, impulsiveness, agitation, and resistance to medication administration. The assessment failed to identify behaviors that posed a risk to R1. The assessment failed to identify an individualized abuse prevention plan with specific interventions to prevent abuse to R1 and R1's abuse towards others. The licensee's policy titled, 2.44 Vulnerable Adult Maltreatment, dated August 1, 2021, indicated licensee would develop individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an agency staff accurately documented and provided scheduled services for one of three residents (R1) with records reviewed. Agency staff falsely documented they performed safety checks on R1 during the time R1 was lying on the floor in his room. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01640		

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01640	Continued From page 4 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1's medical record was reviewed. R1 received services for diagnoses that included Parkinson's disease, dementia, and agitation. R1's medical provider notes dated August 9, 2022, indicated R1 had obsessive compulsive behaviors, wandering, and agitation. R1's service plan dated August 4, 2022, indicated R1 was at risk for falls and required hourly checks at nighttime. R1's service plan indicated hourly checks would be completed at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m., 6:00 a.m., and 11:00 p.m. R1's treatment administration record dated August 24, 2022, indicated safety checks were completed at 12:00 a.m., 1:00 a.m., 2:00 a.m., and 3:00 a.m. Video footage dated August 23, 2022, at 11:10 p.m., indicated R1 fell in his room. Video footage dated August 24, 2022, at 3:05 a.m., indicated family responded to R1 and alerted facility staff. Video footage indicated the resident was on the floor for approximately four hours unattended by staff. Email from licensee to family dated August 24, 2022, at 12:12 p.m., indicated agency staff were	01640		

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01640	Continued From page 5 working during the night of the fall. The email indicated there was confusion with agency staff about services R1 required. During an interview on October 12, 2022, at 3:45 p.m., registered nurse (RN)- C said unlicensed personnel (ULP) should provide education to agency staff before they leave their shift. The licensee's policy titled, Medications and Treatments, dated August 1, 2021, indicated licensee would communicate individual needs of each resident to ULP. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one resident (R1) reviewed was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 6 maltreatment occurred.	02360		