Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282277926M
Compliance #: HL282274869C

Date Concluded: November 6, 2023

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: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) abused a resident when the AP restrained the resident's arms to force medication into the resident's mouth, causing red marks and bruising. It is also alleged the AP was verbally abusive and rough with the resident while providing services.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The facility provided appropriate training and supervision of the AP. A witness observed the AP hold down the resident's hands, shove medications into the resident's face, and verbally taunt the resident.

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 incident reports, personnel file, facility documentation, policies,

and procedures related to resident rights, code of ethics, medication administration, and maltreatment of vulnerable adults. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living memory care unit. The resident's diagnoses included dementia, compression fracture, pain, and osteoporosis. The resident's service plan included assistance with medication administration, toileting, showering, grooming, hygiene, dressing/undressing, meals, housekeeping, and hourly safety checks.

A report indicated a witness observed the AP verbally abuse the resident and physically abuse the resident when the AP grabbed and restrained the resident's hands leaving bruises. The report indicated the witness also observed the AP force medications on a spoon onto the resident, pressing the spoon onto the resident's mouth, and leaving red marks on the resident's face.

During an interview, the witness stated the resident was not herself on the day of the incident, as she had been diagnosed with a urinary tract infection. The witness stated, due to the resident acting out, she asked the AP for help getting the resident ready for bed. The witness stated the AP picked up the resident by herself and aggressively put her on the toilet. The witness stated the AP "ripped [the resident's] shirt off and pulled [the resident's] pants off so fast, her shoe stuck." The witness stated the AP then "ripped" the resident's socks off, which upset the resident. The witness stated the resident began to scream about her socks being off and the AP taunted the resident, saying "Oh, you want your socks? You better be good!" and grabbed the resident's medication. The witness stated the AP then held down the resident's hand, pressed the spoon containing the resident's medications onto the resident's mouth, pushing as the resident turned her head from side to side. The witness stated the resident told her she did not want the AP back in her room. The witness reported the incident to the nurse.

During an interview, a nurse stated she assessed the resident immediately after the incident, observed, and photographed the red marks on the resident's face as well as the bruising on the resident's hands. The nurse stated the resident was shaking and crying during the assessment, and the resident questioned "Why is that girl so mad at me?" (Photographs of the resident's injuries were shared with the investigator.)

During an interview, the AP stated the resident hit and pinched her while the AP tried to help. The AP stated she tried to give the resident her medication, but she refused to open her mouth. The AP stated she worked a double shift that day and remembered that the resident did not have any bruising on her hands in the morning but denied abusing the resident. The AP stated, "I would never do that."

During an interview a family member stated the AP was a new staff and the facility provided all the details about the witnessed rough cares with the resident. The family member stated they had never seen that type of behavior with any of the other staff, and stated the family was very happy with the cares the resident received.

In conclusion, abuse is substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“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:
(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;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP no longer works for the facility.

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:
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 10/25/2023

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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL282274869C/ #HL282277926M; #HL282275107C/ #HL282278006M On October 25, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 88 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL282275107C/ #HL282278006M, tag identification 1690 and 2360. The following correction order is issued for #HL282274869C/ #HL282277926M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure there was a medication management system in place to prevent diversion of narcotics for two of two	01690	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State	

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01690	Continued From page 2 residents (R1 and R2) reviewed for missing medications when 28 Oxycodone (a narcotic pain medication) tablets were found to have been replaced with other medications. This had the potential to affect all 88 residents receiving services. It could not be determined if harm occurred. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1 R1 moved into the facility on August 25, 2022, due to diagnoses that included dementia, compression fracture of lumbar vertebrae, low back pain, history of hip replacement, and osteoporosis. R1's Medication Assessment dated August 4, 2023, indicated 'yes' to risk of diversion of controlled medications [narcotics], with an intervention to "see policy 6.25 storage of medications". R1's Vulnerable Assessment/Abuse Prevention Plan dated August 16, 2023, indicated R1 had chronic pain with scheduled and as needed (PRN) Oxycodone (a narcotic pain medication). R1's Medication Sheet (a document that recorded weekly medication set up in a medication planner	01690	Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01690	Continued From page 3 by a licensed nurse) dated August 2023, indicated R1 was prescribed Oxycodone 5 milligrams (mg) one-half tablet at 8:00 a.m., one tablet at 12:00 p.m., one-half tablet at 4:00 p.m., and one tablet at 8:00 p.m. The medication sheet indicated R1 also had available Oxycodone 5 mg, one tablet every two hours PRN for pain. The Medication Sheet document did not provide a description of the pill, such as shape, color, or markings. The Medication Sheet document indicated licensed practical nurse (LPN)-G set up R1's weekly medication planner on August 1, 8, 15, and 22, 2023. R1's Service Plan dated August 25, 2023, indicated R1 received medication management services from the licensee and directed staff to "give 8am meds from am slot of weekly med planner, give meds from noon slot of weekly med planner, give 4pm meds from pm slot of weekly med planner, and give 8 pm meds from bedtime slot of weekly med planner." On October 26, 2023, at 3:30 p.m. the Minnesota Department of Health investigator observed R1's locked medication cupboard in her apartment. Inside the cupboard were medication planners with R1's medications placed inside. The medications in each planner slot were mixed, identified by time to administer but each pill was not specifically identified. For example, all R1's 8:00 p.m. medications were together in one slot of the planner. R1's PRN medications were also stored in the cupboard in separate medication planners labeled as PRN with the medication name and dose, in smaller amounts for use as needed. Observation of R1's PRN Medications document (located inside R1's apartment in the locked	01690		

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01690	Continued From page 4 cupboard) contained record of when R1 received a PRN of Oxycodone 5 mg. The document indicated the date, time given, dose, reason for PRN, effectiveness, number of tablets remaining in the medication planner, and initials of staff who gave the medication. The document indicated that licensed practical nurse (LPN)-F was the only staff who added Oxycodone 5 mg to R1's PRN medication planner between the dates of July 11, 2023, and September 12, 2023. The document also indicated only one staff verified the narcotic count. R2 R2 moved into the facility on April 21, 2017, due to diagnoses that included dementia, chronic pain, and anxiety. R2 received hospice services and passed away on September 16, 2023. R2's Vulnerable Assessment/Abuse Prevention Plan dated July 21, 2023, indicated R2 had chronic pain in her back, both knees, and shoulders and required scheduled and PRN narcotic pain medication. R2's medication Assessment dated July 21, 2023, indicated 'yes' to risk of diversion of controlled medications [narcotics], with an intervention to "see policy 6.25 storage of medications". R2's Medication Sheet dated August 2023, indicated R2 was prescribed Oxycodone 5 mg every four hours (12am, 4am, 8am, 12pm, 4pm, and 8pm). R2's Service Plan dated August 1, 2023, indicated R2 received medication management services from the licensee and directed staff to "give meds from 12am slot of weekly med	01690		

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01690	Continued From page 5 planner, give meds from 4am slot of weekly med planner, give meds from 8am slot and watch [R2] swallow them, give meds from 12pm slot and watch [R2] swallow them, give meds from 4pm slot of weekly med planner, and give meds from 8pm slot of weekly med planner and watch [R2] swallow them." A Vulnerable Adult Maltreatment Report dated August 25, 2023, indicated the director of nursing (DON)-A went into R1's locked cupboard to remove discontinued medications and discovered R1's medication planner contained 17 round white tablets (whole and half) in place of Oxycodone (which was also a round and white tablet). The report indicated the tablets consisted of quetiapine 50 mg tablets (an anti-psychotic medication), hydroxyzine 25 mg tablets (an anti-anxiety medication), and one unidentified pill. The report indicated DON-A investigated R2's medication planner as R2 also received Oxycodone. The investigation indicated DON-A found 15 white tablets and one yellow tablet in place of R2's scheduled 12 a.m. and 4:00 a.m. Oxycodone 5 mg tablets. The report indicated the white tablets consisted of quetiapine 50 mg and hydroxyzine 25 mg, and DON-A identified the yellow tablet as carbidopa/levodopa 25/100 mg (a medication prescribed for Parkinson's disease). Neither R1 or R2 were prescribed hydroxyzine, and R2 was not prescribed carbidopa/levodopa. During an interview on October 25, 2023, at 2:36 p.n. DON-A stated LPN-G set up resident medications in medication planners once per week and unlicensed staff signed off on a paper medication administration record (MAR) when administering the medications to the resident. DON-A stated the MAR did not identify what the pills looked like, so the unlicensed staff were	01690		

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01690	Continued From page 6 responsible for verifying the number of pills that they gave to the resident. DON-A stated LPN-G was also responsible for documenting the number of narcotic pills delivered to the facility, setting up the PRN medication planners, and documenting the narcotic count weekly. DON-A stated there was not a system in place at the time of the incident to verify the narcotic pill count with another nurse. DON-A stated each resident's medication cupboard contained only a few PRN narcotics and the rest were stored under double lock in a storage room only accessible by licensed nurses. DON-A stated she reviewed the medication planners for all residents on Oxycodone as part of the investigation of the missing Oxycodone and found no additional discrepancies. DON-A stated she interviewed LPN-G, who denied taking R1 and R2's Oxycodone and could offer no explanation of why quetiapine and hydroxyzine were in the medication planners in place of the Oxycodone. During an interview on October 30, 2023, at 2:47 p.m. family members (FM)-B and C stated R1 experienced variability in pain control before the incident and after the incident. During an interview on October 31, 2023, at 10:00 a.m. unlicensed personnel (ULP)-E stated she received medication administration training from the facility that included the five rights (right resident, right medication, right dose, right time, and right route). ULP-E stated the pills were set up in the medication planner, so staff counted the number of pills in the slot and compared it with the MAR. During an interview on October 31, 2023, at 12:43 p.m. ULP-F stated the process for giving medications included getting the medication	01690		

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01690	Continued From page 7 planner out of the resident's locked cupboard and making sure the slot contained the right number of pills. ULP-F stated the facility trained her on the five rights of medication administration, but the procedure was to count the number of pills in the medication planner slot to verify accuracy with the resident's MAR. The Medication Management-Administration and Set-up policy dated August 1, 2021, indicated for assistance with medications from the dosage box system (medication planners) the unlicensed staff will refer to the medication profile listing the medication name, dosage, date, and time administered. The policy indicated unlicensed personnel would verify the medications were set up correctly in the [medication planner] before administration to the resident. The Medication Management-Assessment, Monitoring, and Reassessment policy dated August 1, 2021, indicated a medication assessment must identify interventions needed to prevent diversion of medication by the resident or others who may have access to the medications. The Medication Storage policy dated August 1, 2021, indicated schedule 2 drugs (narcotics) shall be stored under a double lock system and stored separately from other medications, except in weekly set-up or PRN medication planners. TIME PERIOD FOR CORRECTION: Seven (7) Days	01690		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 8 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	