Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL28352045M
Compliance #: HL28352046C

Date Concluded: July 22, 2021

Name, Address, and County of Licensee Investigated:
Ebenezer Management Services
7505 Metro BLVD
Edina, MN
Hennepin County

Name, Address, and County of Housing with Services location:
Arbor Glenn Senior Living
11020 39th Street N
Lake Elmo, MN 55042
Washington County

Facility Type: Home Care Provider

Evaluator's Name: Zalei Lewis, 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.

Allegation(s): The employee grabbed ahold of the client and pulled her upright and out of another client's bed. The employee was also verbally aggressive toward the client.

Investigative Findings and Conclusion:
Neglect is substantiated. The facility was responsible for the maltreatment. The facility was aware the client wandered into the room of the client whose bed she was found in that evening. Clients sleeping together is not a common practice in this memory care unit. There were no interventions or instructions for staff address this behavior. The failure to address the behavior in the client record, develop interventions in the client care plan, advise staff how to address the behavior, contributed to an incident where the client was bruised.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted family of the client and the client was interviewed. The investigator performed an on-site visit and engaged in facility record and policy review.

The client resides in a memory care unit. Her diagnoses included unspecified dementia, chronic kidney disease, hypertension, degenerative disc disorder, degenerative joint disorder of the knee, and anxiety. The client received assistance with activities of daily living, such as grooming, dressing, and laundry. She also received safety checks and medication administration.

A staff member was checking on the client and did not find her in her room. The client was found in bed with another client, in another client's room. Multiple staff members were in the room trying to get the client out of bed and back to her own room. One staff member grasped the client's hand or arm and walked the client back to the client's room. The staff member spoke to the client on the walk to the client's room.

Review of the internal report reveals, "Resident does have a history of staying in other resident's room…D/T cognitive needs, staff are to encourage residents to separate into their own rooms at NOC. Staff entered room to provide redirection, resident was agitated and became combative."

Documentation from staff included in the internal report, "(the client) continued to refuse to leave, stating she was fine where she was when (staff) began raising her voice and physically grabbed (the client) by the right arm and forcibly removed her from the bed…(staff) was bent over other resident attempting to comfort her as well as body shield her. (The client) had begun swinging at care staff…hit (the other client) on the shoulder." Staff also documented "(staff) were still there trying to get (the client) unscared and to feel safe again. (The client) was still looked scared when we left her room. (The client) locked her door behind us and stayed in her unit."

The client's chart indicated, "Resident does have a history of staying in other resident's room." The care plan lists forgetful, paranoid at times, and alert and orientated to person. The interventions for these issues refers to a care plan tool used for all memory care clients.

During interview, one staff member stated there were no interventions in the care plan or suggested by the facility to help staff when the client went into others clients' rooms. A different staff member stated, "The care plans were on the phones...there were no interventions." and "They kind of expected me to use what I already know...It's kind of like oh you're here, great, now go."

Interviews with staff about the incident included statements about the client who entered the room hitting the client who resided in the room such as "she (the client) started kicking, hitting, the other resident, so we, you know, as we protect the other resident from her kicking because she was in her bed." And "Yeah, she (the client) did hit her (the other client)."

During an interview with a staff member who reviewed video surveillance staff stated, "could see that she (the client) was very, very upset…she's (the client) quick on her feet, but this was

being like dragged along into the room." The staff member stated the bruise found on the client later was "absolutely" related to this incident.

In conclusion, neglect was substantiated. The facility failed to implement appropriate interventions for a known behavior of the client, which foreseeably resulted in an altercation and a bruise to the client.

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

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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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

Action taken by facility:
The facility updated the client care plan to include allowing the client to remain in the bed of the client if found there. The alleged perpetrator is no longer an employee of the facility.

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 651-201-4890 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.

cc:
The Office of Ombudsman for Long-Term Care
Washington County Attorney
Lake Elmo City Attorney
Lake Elmo Police Department