

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285137644M
Compliance #: HL285134302C

Date Concluded: January 2, 2024

Name, Address, and County of Licensee

Investigated:

Oak Terrace Senior Living
622 Aberdeen Avenue
Jordan, MN 55352
Scott County

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

Evaluator's Name:

Katie Germann, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:

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), facility staff, abused a resident when the AP restrained the residents' arms and forced the resident to take medication.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP, a facility licensed staff, directed unlicensed staff to hold the resident's arms while the AP forced medications into the resident's mouth. The AP held the resident's head to force the medications into the resident's mouth and held the residents mouth closed to force the resident to swallow the medication.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of staff training, staff schedules, facility policies and procedures, and resident medical records. Also, the investigator observed staff medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance. The resident's service plan included assistance with dressing, bathing, grooming, toileting, and medication administration. The resident's assessment indicated the resident had a history of refusing cares.

Nursing progress notes indicated the AP, and two unlicensed personnel, entered the resident's room to administer his medications. The resident attempted to hit the staff. The two unlicensed staff held the resident's arms while the AP held the resident's head in place and "snuck" the tip of a syringe (where the resident's medication was) into the resident's mouth. The AP held the resident's mouth shut for a few seconds to prevent the resident from spitting the [unnamed] medication out.

Nursing progress notes from the next day indicated the AP asked the unlicensed staff to hold [restrain] the resident's hands so the AP could administer the resident's medication. The AP mixed the residents medication with a small amount of water and put it into a syringe. The AP held the resident's head and "pried" his mouth open enough to get the syringe in. The AP held the resident's lips closed so the resident would not spit the medication out. The AP documented, "during the entire process the resident's face was very, very angry."

The residents nursing progress notes from a week prior indicated the AP administered olanzapine (an antipsychotic medication) because the resident was, "starting to get anxious and rude". The nursing notes indicate the resident was refusing to have his oxygen levels checked and when the AP asked the resident to sit still, the resident told the AP to "go to hell". The nursing notes indicated, "Due to resident's bad/difficult behavior, olanzapine was given so staff would be able to care for resident without too much hassle. Resident was then calmer and more willing to work with staff, not against them".

During an interview, a facility nurse stated she contacted the AP immediately after reading the progress notes the AP wrote regarding forcing the resident to take the medication. The nurse stated the resident was able to take medications and staff were not directed to dissolve the resident's medication in water and administer them in a syringe. The nurse stated the AP was re-educated on use of restraints and the residents right to refuse.

When interviewed, an unlicensed staff stated they [the AP and 2 unlicensed staff] tried to convince the resident to take the medications, but the resident continued to refuse. The unlicensed staff stated she held the resident's hands while the AP administered the medications. The unlicensed staff stated she understands this was considered a restraint and has been retrained.

During an interview, the AP stated she asked two unlicensed staff to assist with administering morphine (a narcotic medication) to the resident due to the resident possibly having pain at the time. The AP stated when attempting to administer the residents' medications the resident was

moving his head back and forth. Both of the unlicensed staff took one of the resident's arms and held them at the resident's waist. The resident was saying, "no, no, no," and began squeezing his mouth shut. The AP stated she put the syringe with the morphine in the resident's mouth and the resident appeared as if he would spit out the medication. The AP held the resident's lips closed until the resident swallowed the medication. The AP stated on another day the resident was refusing cares so the AP administered olanzapine so the staff could more easily care for the resident.

In conclusion, the Minnesota Department of Health determined abuse was 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;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

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.

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility provided education to staff regarding resident's rights.

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.

You may also call 651-201-4200 to receive a copy via mail or email

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

Scott County Attorney

Jordan City Attorney

Jordan Police Department

Minnesota Board of Nursing

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28513 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/17/2023 |
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| NAME OF PROVIDER OR SUPPLIER OAK TERRACE HOUSING OF JORDAN | STREET ADDRESS, CITY, STATE, ZIP CODE 622 ABERDEEN AVENUE JORDAN, MN 55352 |
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| (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 |
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| 0 000 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL285134302C/#HL285137644M</p> <p>On October 17, 2023 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 59 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #H285134302C/#HL285137644M, tag identification 2360.</p> | 0 000 | | |
| 02360 | <p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> | 02360 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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| 02360 | <p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of one of one residents (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p> <p>Please refer to the public maltreatment report for details.</p> | 02360 | | |