Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327306585M
Compliance #: HL327302361C

Date Concluded: February 12, 2024

Name, Address, and County of Licensee Investigated:
Stanton House W Services Inc
4847 Bryant Avenue North
Minneapolis, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Not Substantiated

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) neglected the resident when they failed to provide wound care. In addition, the AP abused the resident when she called the resident names. There was also an alleged concern of the AP's conduct in handling the resident's money.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect and abuse were not substantiated. The facility communicated the resident's refusals of care to her provider, family, and case manager. The investigation lacked evidence the facility did not provide cares as the resident would allow. Although the language did not meet the definition of abuse regarding name calling, it was a concern for violating the resident's dignity. In addition, the investigation did not find evidence of any mishandling of the resident's money.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members, the case worker

and the resident's positive support specialists. The investigation included review of the resident records, death record, hospital records, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia and morbid obesity. The resident's service plan included assistance with hygiene, bathing, toileting, and transfers. The resident's assessment indicated she was alert and oriented to person and place. The resident required two person assist for transfers and uses an electric wheelchair for mobility.

WOUND ALLEGATION

While using a community transportation service, the resident's left foot sustained an injury when exiting the vehicle. The staff provided protective boots to both feet, elevated the injured foot twice daily as tolerated and encouraged the resident to have the wound evaluated by a physician. The wound worsened and the resident became hospitalized.

Hospital records indicated the resident was hospitalized for 12 days. The resident required below the knee amputation of the left leg due to poor healing prognosis of the foot wound related to poor circulation of leg. Hospital progress notes indicated multiple incidents of the resident's refusals of care and self-neglect. The resident refused cares, blood draws, medication, food, and medical monitoring such as vital signs.

A facility wound treatment sheet indicated the resident had orders for daily would care to the amputation site and staff completed wound care.

Approximately two months later, wound clinic notes indicated the wound did not have signs of infection and wounds were healing with daily wound care at facility.

During investigative interviews, multiple staff members stated the resident struggled with depression and self-neglect. Staff members stated the resident refused care frequently for extended periods of time. The staff stated the resident was verbally abusive to them, would throw objects and run her wheelchair in to them and furniture on purpose. Staff stated the resident refused to go to the hospital as recommended by the nurse and her provider, resulting in further health complications.

During an interview, a nurse stated the resident received wound care at the wound care clinic, and from wound care nurses that came to the facility. The nurse stated she did wound care at the facility for the resident when she could not get to her appointment, or the home visiting nurse could not make it to the facility. The nurse stated the resident was abusive towards the facility staff and resistive to care, including refusing to get out of bed. The nurse stated the resident refused to use the shower, so the resident received a bed bath nearly daily.

During interviews with the resident's family members, the family stated the resident was her own decision maker and had mental illness. The family member stated the resident refused to go to the doctor when she should have. The family stated the resident may have been refusing care because it was the last thing, she had control of.

VERBAL ABUSE ALLEGATION

Providers from the community provided contracted services to the resident at the facility. While in the presence of the of the resident and AP, the providers witnessed the AP calling the resident a "baby," speaking down to the resident, and was dismissive to the resident's communication with the AP.

During an interview, a facility resident denied hearing staff speaking to residents disrespectfully. The resident stated the staff are very good to him and speak to him with dignity. The resident stated he has not heard any other residents voicing concerns.

During investigative interviews, multiple staff member denied inappropriate verbal communication to the resident such as name calling or demeaning language use toward the resident.

During an interview, community provider #1 stated they noticed staff were not nice to the resident and told her to stop being a baby. Community provider #1 stated when the resident voiced concerns to staff, they reacted dismissively to the residents' concerns and told her she was fine.

During an interview, community provider #2 stated they witnessed the AP calling the resident a baby. Community provider #2 stated the AP was aggressive, would yell, and told the resident and other staff to shut up. Community provider #2 stated she witnessed the AP take the resident's bank card from the resident's purse, and never saw receipts for any purchases.

During an interview, a family member stated she witnessed the AP tell the resident to toughen up.

During an interview, the AP stated when the resident sustained an injury to her foot, she refused to go to the hospital to have it evaluated. The AP stated the resident said she did not care about it, and it could fall off for all she cared. The AP set up a telehealth appointment with the resident's doctor, who tried to convince the resident to come in for an appointment, and the resident refused to go. The AP stated the nurse or outside wound services handled wound care. The AP stated the resident had a personality disorder, and sometimes could be very polite and nice, then very rude, disrespectful, non-compliant or just completely ignore you other times. The AP stated the resident never expressed any complaints about her care to her. The AP stated the resident was in control of her own money and paid her rent in cash. The resident withdrew money from an ATM, and sometimes made more than one transaction to get the whole amount out. The resident also withdrew cash for her trips to the store. The AP stated she

provided the resident receipts for her rent. The AP stated she took good care of the resident. The AP denied calling the resident names.

In conclusion, the Minnesota Department of Health determined abuse and neglect were not substantiated.

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

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:
(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:
(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;

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility repeatedly encouraged the resident to allow for cares and medical treatment.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32730	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE W SERVICES INC	4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430

(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, 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: #HL327306585M/HL327302361C On January 17, 2024, 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 3 residents receiving services under the provider's Assisted Living Care license. The following correction orders are issued for #HL327306585M/HL327302361C, tag identification 1950, 2350.	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.	
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 1 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to document the signature of the person who administered a treatment, as required for 1 of 1 residents (R1) reviewed. 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 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). The findings include: R1's diagnosis includes paraplegia and morbid obesity. R1's service plan dated May 11, 2023, indicated R1 received assist with catheter care, behavior management, eating, bathing, transfers, medication administration and wound care. During an interview on January 30, 2024, at 12:16 p.m., registered nurse (RN)-G stated she completed the wound care, however, encouraged	01960		

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01960	Continued From page 2 the unlicensed personnel (ULP) to sign R1's record for the completion of wound care and not herself. RN-G stated that was how she involved the ULP's in R1's wound care. During an interview on January 31, 2024, at 11:00 a.m., licensed assisted living director (LALD)-H stated it was not allowed for a staff member to sign documentation of completion of wound care that was completed by another staff member. During an interview on February 1, 2024, at 2:30 p.m., ULP-I stated she would help RN-G in the room while RN-G did the wound care for R1. ULP-I stated she signed the R1's record, so the record reflected it as complete. R1's medication administration records dated May 1 2023 through June 30 2023, have twenty-nine days of signatures documented by ULP indicating the completion of wound care for R1. TIME PERIOD FOR CORRECTION: 7 days	01960		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to treat a resident with courtesy and respect for 1 of 1 residents (R1) reviewed when staff called R1 a baby and criticized her feelings.	02350		

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02350	Continued From page 3 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 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). The findings include: R1's diagnosis included paraplegia and morbid obesity. R1's service plan dated May 11, 2023, indicated R1 received assist with catheter care, behavior management, eating, bathing, transfers, medication administration and wound care. The licensee-provided document titled "Staff Annual Training Record", undated, indicated staff receive annual training on communication skills, preserving the dignity of the resident, and showing respect for the resident. During an interview on January 19, 2024, at 1:00 p.m., R1's case manager (CM)-B stated while attending a meeting with R1 and facility staff, she heard the staff tell R1 she had nothing to cry about. During an interview on January 22, 2024, at 1:00 p.m., support professional (SP)-C stated staff were not nice to R1 and would talk down to her. The staff told R1 to stop being a baby. During an interview on January 22, 2024, at 2:00 p.m., family member (FM)-D stated while visiting R1, she witnessed licensed assisted living director (LALD)-H tell R1 to toughen up and to stop being dramatic.	02350		

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02350	Continued From page 4 During an interview on January 25, 2024, at 9:00 a.m., SP-E stated LALD-H was always calling R1 a baby. SP-E stated R1 told LALD-H her chest was hurting and LALD-H told R1 she was just fine and just being a baby. During an interview on January 26, 2024, at 1:04 p.m., FM-F stated during meetings, staff were very condescending and would talk down to R1. TIME PERIOD FOR CORRECTION: 7 days	02350		