Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394258342M
Compliance #: HL394254980C

Date Concluded: February 12, 2025

Name, Address, and County of Licensee Investigated:
Hayden Grove of St Anthony
2601 NE Stinson Parkway
St Anthony MN 55418
Hennepin County

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

Evaluator's Name: Maggie Regnier
Special Investigator

Finding: Inconclusive

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) abused the resident when she crushed the resident's medication, mixed them in milk, and forced the resident to drink it while co-workers held him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP did crush the medications, even though the residents service plan stated do not crush the medications, and the AP mixed the medications in milk for administration. However, there was conflicting and/or a lack of evidence the resident was physically forced to drink the milk and medications. While the technique use during the medication pass may have been poor, it was unclear if abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff and family members. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff

schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, residents and visitors.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia, anxiety, and insomnia. The resident's service plan included assistance with ambulation, medication management and eating prompts. The resident's assessment indicated the resident could be resistant to cares and taking medications.

An internal investigation document indicated one evening the AP crushed the residents evening medications, mixed that with milk and had the resident drink the milk. When asked why the AP did that, the report indicated the AP said the resident had previously refused his medications but liked milk so AP thought that if she crushed the medication and put them in milk, he would drink it. The internal investigation document indicated there was no force used to make the resident drink the milk and medications.

The residents service plan indicated caregivers were instructed to give medication in applesauce, do not crush unless indicated, and to notify the nurse of refusals.

During an interview, a manager stated the AP was educated on proper medication administration, which included not crushing medications unless directed by nursing. The manager also stated that the internal investigation found no used.

During an interview, a nurse stated the resident was assessed by the resident's medical provider after this incident and no sign of injury was identified.

During an interview, an unlicensed caregiver, who witnessed this event, stated the resident drank the milk without force and without difficulty or complaint. This unlicensed care giver also stated that it would be wrong to use force, and he had never seen this at the facility.

During an interview, another witness of the event stated two unlicensed caregivers were at the resident's side while he was sitting in bed to ensure the resident did not tip back, each had a hand on the residents back. This witness stated the AP was verbally forceful in trying to get the resident to drink the milk.

During an interview, the AP stated it was sometimes difficult to get the resident to take his medications, however she denied crushing his medications. The AP stated the resident liked milk and this was part of the effort to encourage him to take his medications.

The Minnesota Department of Health determined that abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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:
(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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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 due to impaired cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility re-educated caregivers regarding medication pass technique including following instructions regarding crushing medications. The AP was no longer employed at the facility.

Action taken by the Minnesota Department of Health: No further action at this time.

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
	39425	A. BUILDING: _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE OF ST ANTHONY	2601 STINSON PARKWAY ST ANTHONY, MN 55418

(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 On January 15, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL394254980C/#HL394258342M. No correction orders are issued.	0 000		