Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H51486924M
Compliance #: H51482292C

Date Concluded: February 12, 2024

Name, Address, and County of Licensee Investigated:
The Estates at St. Louis Park
3201 Virginia Ave. South
St. Louis Park, MN 55426
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Brooke Anderson, RN
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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff member, abused the resident when the AP grabbed the resident's ankles when repositioning the resident, told the resident he had a gun and was going to shoot the resident, and masturbated in the resident's room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to incomplete and conflicting accounts of the incidents, it could not be determined if maltreatment occurred. Varying accounts of the incidents were provided by the resident, the AP denied the allegations, and there was no witness to the incidents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, procedures, and related federal complaint survey documentation.

The resident resided in a nursing home. The resident's diagnoses included schizoaffective disorder and bipolar disorder. The resident's care plan included assistance with two staff for transfers, bed mobility, and toileting. The resident's assessment indicated the resident had a history of delusions and hallucinations.

Complaint documents indicated a staff member/alleged perpetrator (AP) was rough when providing cares to the resident. The complaint documents indicated the AP grabbed the resident's ankles and caused pain when positioning the resident. The AP also told resident he had a gun and was going to shoot the resident and himself. The complaint documents further indicated there was a report that the AP masturbated in the resident's room.

The resident's medical record indicated the resident had a decline in cognition over the last year and over the past six months experienced an increase in paranoid hallucinations/delusions of a man with a gun coming to shoot her. Medical provider notes also indicated a history of delusions about the AP, including that he masturbated in her room.

Facility documents indicated when management became aware of the concerns involving the AP, they completed an internal investigation. The internal investigation included an assessment and interview with the resident. There was no physical evidence of injury to the resident as the resident refused a skin check. The resident denied physical abuse but reported verbal abuse by the AP. Additional residents and facility staff were also interviewed as part of the internal investigation, but management was not able to verify any witness to the alleged incidents.

During an interview, the AP indicated the resident resided on the mental health unit and had a history of accusing people of different allegations. The AP stated the resident experienced delusions but staff were not good about documentation of the resident's behaviors and delusions. The AP denied verbally or physically abusing the resident and denied masturbating in the resident's room. The AP stated he treated the resident the way he would want to be treated.

During investigative interviews with the federal surveyor, multiple staff members stated they were unaware of the resident's concerns about the AP. Multiple staff members stated the AP spoke in a loud voice and was often interpreted in the wrong way and his jokes were taken out of context.

During an interview, the resident stated the AP flirted with her in a sexual manner and masturbated in her room on two occasions. The resident stated she did not see the AP masturbate but that the AP took a long time to put her to bed and she "knew what he was doing." The resident stated after the AP was terminated, he called her five or six times on her "yassing" and threatened to shoot her. The resident explained a "yassing" was a communication device but that it was not a phone.

During an interview, facility management stated the AP had a history of joking with residents but did not realize they did not appreciate his humor. Facility management stated the resident was cognitively intact but had a history of delusions. Facility management indicated when the resident held her hand up to her face and talked into it like a phone, the resident was talking on her “yassing”. Facility management indicated their internal investigation identified a pattern of concerns regarding the AP’s communication with residents and as a result of the investigation, the AP’s employment was terminated.

During an interview, the resident’s family member stated the resident did not report these specific incidents to them, but stated the resident experienced daily delusions. The family member stated the resident had a history of sexual delusions, including delusions related to men masturbating in her room.

In conclusion, the Minnesota Department of Health determined 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.

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

Action taken by facility:
The facility completed an internal investigation which included resident interviews, staff interviews, and education regarding the vulnerable adult policy and when to report abuse.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00943	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H51486924M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		