Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Ma Maltreatment Report #: H51823227M
Compliance #: H51825119C

Date Concluded: June 23, 2023

Name, Address, and County of Licensee Investigated:
Villa at St. Louis Park
7500 22nd St West
St. Louis Park, MN, 55426
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Danyell Eccleston, 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, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) emotionally abused a resident when the AP placed her hand over the resident's mouth which caused the resident to become upset and anxious.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There is conflicting information regarding the AP putting her hand over the resident's mouth. There is information when the incident occurred, the AP continued to provide care after the resident told the AP to leave her alone, however, this did not rise to the level of maltreatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of employee records, medical records, facility policies, and police report.

The resident resided in a skilled nursing facility. The resident's diagnoses included dementia, anxiety, and generalized weakness. The resident's assessment indicated the resident was forgetful with moderate cognitive impairment. The resident required staff assistance with bathing, transferring, mobility, toileting, dressing, and personal hygiene. The resident's care plan indicated the resident was often tearful and distressed and felt staff were ignoring her or didn't like her even when care had recently been provided.

Recorded audio of the incident revealed the interaction between the AP and the resident, however, not all conversation was discernable. Audio indicated the resident requested bathroom assistance, told the AP to stop yelling at her and to leave her alone and that she did not feel well. The recorded audio indicated the resident called out "get your hands off my mouth, "you don't put your hands on my mouth." The audio also indicated the AP was singing the resident's name when the resident was calling out.

Review of an internal facility report indicated the resident reported feeling safe at the facility after the incident.

During an interview, an unlicensed staff member stated she was in the room with the resident and AP assisting the resident to use the commode when the incident occurred. The unlicensed staff member stated the resident would often raise her voice and become upset when the resident believed staff were not present often enough to assist the resident. On the day of the incident, the resident was frequently using her call light to use the commode during a time when other residents needed cares. The AP told the resident she should not be using her call light frequently and the resident became upset and told the AP to stop talking to her. The AP continued to talk to the resident and the resident became increasingly upset. The unlicensed staff member stated she did not witness the AP touch the resident inappropriately or put her hand over the resident's mouth but did think the AP should have stopped talking when the resident requested the AP to stop.

During an interview, a second resident stated the day of the incident she went to the resident's apartment after she heard yelling. The resident was upset stating staff had been mean to her and the AP covered the resident's mouth with her hand. The second resident did not witness the incident.

During an interview, the AP denied putting her hand over the resident's mouth or emotionally abusing the resident.

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: No, per family request.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility management educated all staff regarding immediately reporting concerns with resident abuse and neglect of a resident. AP is no longer employed at facility.

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
	00278	A. BUILDING: _____ B. WING _____	C 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST LOUIS PARK LLC	7500 WEST 22ND STREET 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 #H51823227M, 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		