Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5518158M
Compliance #: H5518155C

Date Concluded: April 20, 2022

Name, Address, and County of Licensee Investigated:
St. Therese Home
8000 Bass Lake Road
New Hope, MN 55428
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) physically abused the resident when she pushed the resident into his wheelchair, kicked him and caused skins tears.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. Staff witnessed the AP kick the resident, push him back into a wheelchair and forcefully grab his arms when he became agitated during a blood pressure check. The resident sustained two skin tears to his right arm.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and the resident's family. The investigator reviewed the facility's internal investigation, resident records, personnel records, policies and incident reports.

The resident lived in memory care. His diagnoses included Parkinson's disease, psychotic disorder with hallucinations, orthostatic hypotension (low blood pressure with position changes), an L1 lumbar compression fracture and a history of falls. The resident's care plan indicated he used a walker to walk and required supervision due to an unsteady, shuffling gait from Parkinson's. The resident had a history of wandering, hallucinations, suspicious and fearful behaviors and resisting cares. His care plan instructed staff to respect his wishes and re-approach later. The resident had cognitive impairment and his care plan instructed staff to allow him time for decision making and time to respond.

One morning, the AP attempted to take the resident's blood pressure before medication administration. The resident was seated in a wheelchair in the day room near the nursing station. The resident presented as restless, agitated and resisted the blood pressure check by the AP. The resident tried standing up from the wheelchair. The AP told the resident to sit down and the resident kicked out at her. The AP kicked the resident and pushed him back into a seated position in the wheelchair. She forcefully grabbed his wrists and held his arms inside the wheelchair. Two nurses and an unlicensed staff witnessed the incident. A staff nurse intervened and contacted the supervisor who sent the AP home and suspended her from the schedule while administration conducted an internal investigation. The resident sustained two skin tears: one 1.8 centimeters (cm) long on top of his right hand, and one 4.8 cm long on the lower right forearm. There were no injuries to the lower extremities.

During an interview, the AP said when she came to work that morning around 6:00 a.m., there were several residents having "behaviors" and yelling. The AP said she was not calm or in a good mood because of this. She found the resident not dressed, not fed and agitated. Around 7:15 a.m., the AP tried to take the resident's blood pressure, but when she placed the cuff on his arm he resisted, stood up from the wheelchair, struck out and kicked at her. The AP said she did not know how the resident got skin tears, she just moved his arms onto his lap so he could not hit her or bump his arms on the wheelchair arm rests. The AP said other staff yelled at her to stop "pinching" the resident and reported her to the supervisor. The AP said she did not pinch or kick the resident, but she did move her leg in front of the blood pressure machine to protect it from the resident kicking it over onto the floor. The AP said the staff members were across the room and too far away to see her clearly. The AP dressed the resident's skin tears before she called his family member about the incident. The AP said she did not ask other staff to help her with the blood pressure because they were all busy and not in good moods. She could not walk away from the resident because he would stand up and fall or take his clothes off. The AP said she should walk away and leave the resident alone or distract him, but she did not do anything wrong.

During an interview, a registered nurse said the resident was restless that morning and the AP seemed upset when she came to work. The nurse was seated at the nursing station and saw the AP trying to perform a blood pressure check on the resident before medication administration, but the resident was not sitting still. The nurse asked the AP to leave the resident alone for a while and come back later but the AP said no she needed to get the blood pressure. The nurse

said the AP continued trying to get a blood pressure 2 or 3 more times and the resident became more restless. He stood from his wheelchair and kicked out at the AP. The AP kicked the resident in the shin and shoved him back into the wheelchair. The nurse said the AP forcefully held the resident's arms in his lap. The nurse got up and went to the AP and saw the resident's right wrist bleeding. The AP told her the blood pressure cuff caused the skin tears. The nurse said the AP caused the skin tears and contacted the house supervisor to report the incident. The nurse said the AP abused the resident, her actions were not right and not the way they were trained to handle residents. Staff are trained to reapproach the resident two or three times and if he still resists or declines cares, document and let someone else try or wait and come back later.

During an interview, the unlicensed staff member said she was on her way to get ice for a resident. Two nurses sat at the nursing station giving shift report. The staff member heard someone yell "sit down" and "don't do that" repeatedly. The nurses and the unlicensed staff went over to the AP and the resident. The staff member said the resident's wrists were red as if someone had grabbed his wrists hard.

During an interview, the nurse manager said the resident could have delusions and become physically aggressive. Staff are taught to use a calm, slow approach, do not rush residents. Staff should try talking with him before doing cares. If the resident does not want to do something staff should stop, make sure he is safe and reapproach later or have a different staff member approach the resident. The nurse manager said the AP was well trained in dementia cares.

During an interview, the director of nursing said the AP was often too focused on tasks and not customer service. The AP was immediately pulled from the schedule and suspended during the investigation which included interviews with multiple staff and residents.

During an interview, the family member said the AP called her to report the incident that morning and she felt that was inappropriate for her to call directly. The family member said she was contacted by the facility about the incident and that the resident did not recall the event, was on 72-hour wellness checks and an internal investigation was in process.

The AP's training records show she completed and passed computer-based courses on challenging behaviors in dementia care, normal aging versus dementia/Alzheimer's, understanding abuse and self-neglect, and understanding Parkinson's disease. The AP's personnel file included counseling reports for using profanity or potentially offensive language to a resident, poor teamwork with colleagues, poor approach and communication with residents and other customers including co-workers and family, poor nursing standards of practice regarding medications and documentation.

Law enforcement was contacted and came to the facility but did not file a report.

The AP is no longer at the facility.

In conclusion, 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;

Vulnerable Adult interviewed: No, due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
An internal investigation was conducted. The AP is no longer employed by the facility.
The resident was placed on wellness checks and his family contacted about the incident.
Staff education implemented.

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. 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Hennepin County Attorney
New Hope City Attorney
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	C 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE HOME	8000 BASS LAKE ROAD NEW HOPE, MN 55428

(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 #H5518158M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H5518158M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on inteviews and record review, the facility failed to ensure one of one residents (R1) with records reviewed was free from maltreatment. R1 was physically abused. Findings include: On April 20, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	