

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL242533942M
Compliance #: HL242534503C

Date Concluded: October 2, 2024

Name, Address, and County of Licensee

Investigated:

The Cedars
901 Polk Street
Anoka, MN, 55303
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatararo, 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 resident was emotionally abused when the alleged perpetrator (AP), an individual employed with the facility, the resident's guardian, refused to allow the resident to move to a different facility. The resident experienced suicidal ideation. The AP also neglected the resident when the AP refused the resident's dental care causing prolonged dental pain.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined emotional abuse was not substantiated. The AP was not aware of the resident's intended move to another facility therefore, no plan had been made for the resident's discharge. There was not a preponderance of evidence to support the AP's refusal of the resident's move caused the resident's suicidal ideation.

The Minnesota Department of Health determined neglect was not substantiated. The resident received dental care, antibiotics, and pain management on a regular basis.

The investigator conducted an interview with the alleged perpetrator and the resident's case worker. The investigation included review of the resident records, hospital records, related facility policy and procedures. Also, the investigator toured the facility.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, alcohol abuse disorder, and a history of suicidal attempts. The resident's service plan included assistance with medication management, and management of the resident's agitation, anxiety, verbal aggression.

The resident's record indicated one day the resident left the facility with his belongings around 8:00 p.m. and demanded his medications. The resident stated he was moving to a new facility. Staff told the resident they were not aware of the move, and the AP who was the resident's guardian, would need to be contacted regarding the move. Staff told the resident there was paperwork and procedures required to complete the discharge process. The resident said the facility could not hold him there or deny providing his medications. The second facility was not able to admit the resident because they had no providers order for admission. When the resident did not return to the first facility, staff contacted 911 to report the resident as a missing person. That evening, the resident reached out to the AP and told the AP he was at the hospital.

The resident's records indicated the resident's desired location to move to, was not a planned or coordinated discharge.

The resident's hospital record indicated the resident admitted for schizophrenia with mood disorder, with acute exacerbation (increase in severity.) The resident also had suicidal ideation in the context of tooth pain and conflict with his guardian, (AP). The resident arrived and said, "I'm on the verge of losing it." The resident said he found a new place to live, and the AP would not authorize the move. The resident was admitted to the hospital for stabilization, assessment, and treatment of psychiatric symptoms and thoughts of self-harm. The resident discharged back to the facility seven days later.

During an interview, the resident's case manager stated the resident had wanted to move out of the facility and continued to want to move out. The resident found a new facility he wanted to move to, however, the AP declined to sign off to allow the resident to discharge. The AP's refusal to allow the resident to move had caused the resident frustration.

During an interview, the AP stated she was the resident's court appointed guardian and the resident resided at the facility where the AP was employed. The resident had a history of wanting to move out of the facility to various placements. One day, the resident and the resident's siblings arrived at the facility, picked up the resident's personal belongings, told staff he was moving out, and left. The AP said she reached out to the other facility and because the other facility had female residents residing there, the AP denied the move. The resident required a setting of all male residents. The AP said if there was an appropriate facility for the

resident to move to, she would approve the move. The AP also stated the resident had been evaluated and treated by numerous dentists for ongoing dental care and had received treatment. The AP stated the dental providers have been unable to determine the cause of the resident's ongoing jaw pain and dental issues.

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:

(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

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.

Vulnerable Adult interviewed: No, attempted but did not reach.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility coordinated dental care, provided antibiotics, and pain management.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/03/2024
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NAME OF PROVIDER OR SUPPLIER THE CEDARS	STREET ADDRESS, CITY, STATE, ZIP CODE 701 POLK STREET ANOKA, MN 55303
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL242534503C/#HL242533942M</p> <p>On September 3, 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 4 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for #HL242534503C/#HL242533942M, tag identification 0590.</p>	0 000		
0 590 SS=D	<p>144G.42 Subd. 3 Facility restrictions</p> <p>(a) This subdivision does not apply to licensees that are Minnesota counties or other units of government.</p> <p>(b) A facility or staff person may not:</p> <p>(1) accept a power-of-attorney from residents for</p>	0 590		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 590	<p>Continued From page 1</p> <p>any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person.</p> <p>(c) A facility may not serve as a resident's legal, designated, or other representative.</p> <p>(d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee allowed a staff member, vice president (VP), to serve as guardian for one of one resident (R1) reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the facility on August 17, 2023.</p> <p>R1's diagnoses included borderline personality disorder, antisocial personality disorder, history of alcohol abuse, and history of a suicidal attempt.</p> <p>R1's signed service plan dated August 17, 2023,</p>	0 590	<p>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.</p> <p>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.</p>	
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0 590	<p>Continued From page 2</p> <p>and August 19, 2024, indicated the licensee's Vice President (VP)-B signed the service plan acting as R1's guardian.</p> <p>On September 11, 2024, at 10:50 a.m., VP-B stated she was employed with the facility and was currently R1's guardian. VP-B stated she became R1's guardian before R1 moved in. VP-B stated the law states one may not become guardian when employed by the licensee, and said everyone interprets the law differently.</p> <p>The licensee's Facility Restrictions Policy, dated June 6, 2022, revised on August 28, 2023, and September 27, 2023, indicated "neither WPAL [Whispering Pines Assisted Living] or any of it staff may accept a power-of-attorney from residents for any purpose, accept appointments as guardians or conservators of residents, borrow funds from a resident, or borrow personal or real property from a resident. "</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 590	<p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	