Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL258294903M
Compliance #: HL258298376C

Date Concluded: August 11, 2023

Name, Address, and County of Licensee Investigated:
The Alton Memory Care
1306 Alton Street
St. Paul, MN 55406
Ramsey County

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

Evaluator's Name: Holly German, 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) physically abused the resident by placing their hands on the resident's face in a way to force the resident to take medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigation found there was insufficient evidence to determine if abuse occurred. The AP denied the allegations, and the resident could not be interviewed due to her cognitive impairment. Video footage of the day of the allegation was not available for the investigation and per facility review, there was obstructed view of the resident and AP's faces.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, the alleged perpetrator, and unlicensed staff. The investigator contacted a family

member. The investigation included review of the resident's medical record, personnel files, facility incident reports, facility policy and procedures and the facility's internal investigation. Also, the investigator observed medication administration, and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, diabetes, anxiety disorder and mood disorders. The resident's service plan included assistance with medication administration, dressing, grooming, transfers, and walking. The resident's assessment indicated the use of wheelchair and wheeled walker, cognitive impairment, and noted resistance to cares at times.

The facility's internal investigation indicated an allegation was received the AP forcefully gave the resident medications when she refused. There was a lack of evidence in facility video footage due to camera angle pointing toward the resident with the AP standing in front of the resident's face.

The resident's medical record included a physician order around the time of the allegation for the resident to receive her medications crushed due to refusals and difficulty swallowing her pills.

The AP's personnel file indicated she had received appropriate vulnerable adult abuse and neglect training, and had not received previous disciplines, complaints or concerns.

During investigative interviews, multiple staff members stated the resident often refuses cares including toileting and medication administration.

During an interview with the manager, the manager stated the allegation about the AP came to a surprise to him. The manager stated it appeared in the video, the AP stood over the resident who was on the couch, put medications in the resident's hand and the resident threw her medications. The medications were picked up and readministered.

During an interview, the AP stated she did not place her hands on the resident's face and when offering the medication to the resident. The resident opened her mouth and took the medication. The AP did not recall the resident spitting out the medication.

The resident was not able to complete an interview due to her cognitive impairment.

During an interview, the family member stated she was not aware of the alleged incident. She stated the resident can be resistive to cares and difficult to care for. She did not have any concerns with the cares the resident receives or her safety.

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:
(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; Stop here if it is not a restraints issue or sexual abuse.
(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 cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and the AP no longer works for the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON MEMORY CARE	1306 ALTON STREET SAINT PAUL, MN 55116

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL258298376C/#H258294903M On July 18th, 2023, 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 97 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL258298376C/#H258294903M, tag identification 0510, 1750	0 000	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 License Providers. 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 surveyors' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to follow infection control practices for 1 of 1 residents (R1) reviewed. Unlicensed personnel (ULP)-B gave R1 a pill off the floor. 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). The findings include: R1's diagnosis includes Alzheimers disease, anxiety disorder, mood disorders and neurocognitive disorder. R1's service plan dated January 1, 2023, indicated R1 received assistance with toileting, ambulation, medication administration, and dressing. R1's medication administration record (MAR) for the month of January 2023, indicated instances of	0 510		

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0 510	Continued From page 2 medication refusals. R1's assessment on January 5th, 2023, indicated she refuses cares at times, speaks in Spanish, requires assist with medication administration. A nursing note dated January 9th, 2023, at 3:35 p.m., indicated R1 refused all meds despite several attempts by the nurse and ULP. A nursing noted dated January 12th, 2023, at 2:00 p.m., indicated an order was received from R1's provider to crush medications. R1's MAR was updated. A nursing note dated January 18th, 2023, at 10:00 p.m., indicated several unsuccessful attempts were made for R1 to take her medications and have her blood sugar checked. During an interview on July 31st, 2023 at 12:02 p.m, ULP-B stated R1 had spit out medication given by licensed practical nurse (LPN)-A and it landed on the floor. ULP-B then stated she gave that same medication off the floor to R1. The licensee-provided policy Administration of Medication Treatment Therapy by ULP, dated August 1, 2021, indicated infection control precautions must be followed when administering medications. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 3 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure proper training and competency for 1 of 2 employees ((unlicensed personnel) ULP-B) reviewed. 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). The findings include: The licensee provided training records for ULP-B on July 18, 2023. The records lacked documentation of any training or competency on medication administration completed by the licensee. The staffing agency training records dated December 23, 2021, lacked medication administration training.	01750		

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