MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
York Garden
3451 Parklawn
Edina, MN 55435
Hennepin County

Report #: HL27800003

Date: May 1, 2014

Date of Visit: December 6, 2013
Time of Visit: 6:00 a.m. to 1 p.m.

By: William Nelson, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): It is alleged that abuse occurred to a client and was recorded on video. It is also alleged that neglect occurred when the client was not provided with care in accordance with her service plan. In addition, the client had a weight loss because staff did not assure she went to the dining room for meals.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☑ Abuse ☐ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

A preponderance of evidence indicated that abuse occurred on two separate occasions when the alleged perpetrator (AP) spoke to the client in a loud, critical and derogatory manner.

The client was, at times, oriented to person but not place or time. The client was diagnosed with vascular dementia which resulted in difficulty completing familiar tasks, following directions and organizing thoughts.

On 10/20/2013 the family installed a camera in the client's room due to concerns that the client wasn't receiving the care agreed to on the service agreement.

A review of a portion of the video taken on 10/21/2013 showed the AP entered the client's apartment and told the client that it was time for lunch. The client was in bed and did not get up. The AP repeatedly poked and tapped the client on the left shoulder while s/he stated, "come on, come on". The client responded by trying to push the AP's right hand away. The AP was heard to tell the client, that s/he was not going to stop. The client got up and stood by the bed and stared straight ahead. The AP placed his/her hand on the wall and stated in a ridiculing tone, "what are you doing, [*short pause*] today junior". The client stood there with an absent look on his/her face. The AP pushed the client's walker to the client. The client said, "Why don't you just leave me alone"? The AP stated, "Because you don't listen, you don't want to go for dinner, you don't, you don't, you don't, you don't". The client did not respond to the AP's statements.

On 10/23/2013 the video showed the client seated on the edge of the bed with the AP standing next to the client. The AP took the client's pajama shirt off and stated, "You are really frustrating, you know that, that is why I am so rough with you. Put your shirt on". Then the AP quickly put the shirt over the client's head. The client looked down at the shirt and picked at it. The AP then said, "Don't you know how to put a shirt on, you are the slowest person; and you know that it takes you ten hours to put a shirt on". The AP grabbed the client's arms and pulled them through the shirt sleeves. The client did not say anything, did not resist the AP when the client's arms were grabbed by the AP. The AP did not give the client any time to respond. The AP directed the client to take off his/her pants, the client did not react and the AP pulled the client's pants down. In a loud voice the AP stated, "you don't listen to me, you don't do what I tell you to do, I have to be forceful because you don't want to do anything, ever". When the AP walked away the AP said, "You just stand around, you try and get out of everything, you are like a child but you're not, you're a grown ass adult." Then AP turned back

towards the client and the AP pointed his/her finger and stated, "that is what you are, a grown ass adult."

The AP was interviewed on 2/24/2014 at 10:20 a.m. The AP denied that s/he yelled at the client however the AP did admit to being loud and forceful with the client because the client would not listen. The AP stated that s/he did tap the client's legs but s/he never hit the client. The AP said the client did stuff just to get out of doing things. The AP stated that the client needed the AP to be stern and forceful because of his/her illness. The AP denied that any of his/her actions were abusive. The AP acknowledged that s/he was frustrated with the client.

In regards to the client's weight loss, the client was being weighed weekly by the facility and the weight was stable at 105 pounds for the last four weeks before the site visit. The family weighed the client with the facility's scale 5 days after the facility had obtained a weight of 105 and the client's weight was 94 pounds. The facility weighed the client later that same day and the client weighed 95.2 pounds. Correction orders have been issued regarding not following the plan of care by escorting the client to meals.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ individual(s) and/or ☐ facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The individual AP is responsible for the verbal/emotional abuse that occurred. The facility provided education on the Vulnerable Adult Act and on dementia and the treatment of individuals with dementia. The facility provided education on what the staff should do in the event they become frustrated with a resident before the situation escalates.

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.

Compliance:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse
"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:

(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;

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Medication Administration Records

☒ Facility Incident Reports

☐ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☐ Therapy and/or Ancillary Services Records

☐ Skin Assessments

☒ Care Guide

☐ Treatment Sheets

☐ Physician Progress Notes

☐ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☒ Weight Records

☒ Assessments

☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☐ Call Light Audits

☒ Personnel Records/Background Check, etc.

☐ Facility In-service Records

☒ Facility Policies and Procedures

☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ○ Yes ◉ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

(•) Yes ( ) No ( ) N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): (•) Yes ( ) No ( ) N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: (•) Yes ( ) No ( ) N/A Specify: _____

Did you interview the resident(s) identified in allegation: (•) Yes ( ) No ( ) N/A Specify: Attempted but resident unable to answer questions accurately due to dementia

Did you interview additional residents: ( ) Yes (•) No

Total number of resident interviews: 0

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: _____

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: 5

Physician interviewed: ( ) Yes (•) No

Nurse Practitioner interviewed: ( ) Yes (•) No

Interview with Alleged Perpetrator(s): (•) Yes ( ) No ( ) N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ( ) Yes , date subpoena was issued _____ ( ) No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care ☐ Medication Pass ☐ Meals

☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☒ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ◉ Yes ○ No Specify: Video from web camera provided by family

xc: Division of Compliance Monitoring - Licensing & Certification
Hennepin County Attorney
Edina City Attorney
Edina Police Department- Sergeant Viktors Konters

FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27800	A. BUILDING: _____ B. WING _____	C 04/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS	3451 PARKLAWN EDINA, MN 55435

(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 A complaint investigation was initiated to investigate case #HL27800003. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule 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/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 5-20-14

STATE FORM 6899 PDHJ11 If continuation sheet 1 of 12

RECEIVED MAY 20 2014 OHFC

RECEIVED TIME MAY. 20. 4:53PM

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide care and services according to an up to date plan for one of one client (C1) reviewed. Findings include: A review of a portion of the video dated 10/21/13 showed Nursing Assistant B (NA-B) sitting in a chair, the client was in the bathroom with the door closed. NA-B knocked on the door and asked the resident if she was done using the bathroom, the client stated yes. The NA-B stated that it was time for coffee and left the room. The client came out of the bathroom, looked around and said out loud, "Well, I'm just going to lay down," and walked towards the bed. The service plan dated 4/29/13, indicated that the client was to be escorted to and from activities and meals. A review of a portion of video taken on 11/15/13 showed NA-B enter the room, walk up to the client 's bed and asked the client if she wanted to get out of bed, then walked away quickly to the door. While standing in the doorway the NA-B said, "So you don't want to get up", and the client said, "No", and the NA-B said, "OK" and quickly	0 030		

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0 030	Continued From page 2 left the room. The Service Plan dated 4/29/13, indicated that the staff was to offer coffee in the morning and work with the resident to get up and out of the bed. NA-B was interviewed on 3/17/14 and acknowledged that the client needed encouragement to get out of bed and that they are to offer fluids and a small breakfast in the room if the client does not want to go out to the dining area for breakfast. NA-B stated that nursing staff are given assignment sheets that tell them what needs to be done and if there was anything special for that client. NA-B acknowledged that C-1 needed to be "watched and assisted, " in the bathroom. NA-B does not recall any time when she didn't follow C-1's service plan. Time Period for Correction: Thirty (30) days	0 030		
0 085	144A.44 Subd.1(13) Served by people who are competent Subdivision 1. Statement of rights. A person who receives home care services has these rights: (13) the right to be served by people who are properly trained and competent to perform their duties;	0 085		

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0 085	Continued From page 3 This MN Requirement is not met as evidenced by: Based on document review, interview and observations of video tape, the facility failed to ensure that following training, staff were competent to care for clients by following the current service plan for one of one clients (C1) did not have their service plan followed. Findings include: Review of C1's medical record revealed the resident was admitted to the facility on 1/30/12. C1's diagnoses included vascular dementia. Review of C1's service plan agreement, effective date 4/29/13 indicated that C1 required assistance with activities of daily living (ADL) including dressing/undressing, grooming, medication administration, toileting and escorting to and from meals and activities. A review of a portion of the video dated 10/21/13 showed Nursing Assistant B (NA-B) sitting in a chair, the client was in the bathroom with the door closed. NA-B knocked on the door and asked the resident if she was done using the bathroom, the client stated yes. The NA-B stated that it was time for coffee and left the room. The client came out of the bathroom, looked around and said out loud, "well, I'm just going to lay down," and walked towards the bed. The service plan (dated 4/29/13) indicated that the client was to be escorted to and from activities and meals. A review of a portion of video taken on 11/15/13 showed an NA-B enter the room, walk up to the client's bed and asked the client if she wanted to get out of bed, then walked away quickly to the	0 085		

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0 085	Continued From page 4 door, while standing in the doorway the NA-B said, "so you don't want to get up", and the client said, "no", and the NA-B said, "OK" and quickly left the room. The Service Plan (dated 4/29/13) indicated that the staff is to offer coffee in the morning and work with the resident to get up and out of the bed, encourage her to sit in chair. NA-B was interviewed on 3/17/14 and acknowledged that the client needed encouragement to get out of bed and that they are to offer fluids and a small breakfast in the room if the client does not want to go out to the dining area for breakfast. NA-B stated that nursing staff are given assignment sheets that tell them what needs to be done and if there was anything special for that client. NA-B acknowledged that C-1 needed to be "watched and assisted, " in the bathroom. NA-B was asked about training in the care of residents with dementia. NA-B stated that the facility provided dementia training in orientation, annually and they had a special 10 hour program on dementia, part of that discussed how to deal with some of the difficult behaviors clients with dementia present. Time Period for Correction: Thirty (30) days	0 085		
0 090	144A.44 Subd.1(14) Treated with respect Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be treated with courtesy and respect, and to have the patient's property treated with respect;	0 090		

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0 090	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview, record review and review of Compact Disc (CD) video the licensee failed to ensure that a resident was treated with courtesy and respect for one of one client (C1) reviewed. Findings include: Review of C1's medical record revealed the client was admitted to the facility on on 1/30/12 with diagnoses that included vascular dementia. Review of C1's service plan agreement, effective date April 29, 2013 identified C1 required assistance with activities of daily living (ADL) including dressing/undressing. grooming, medication administration, toileting and escorting to and from meals and activities. Review of video recording dated October 21, 2013 revealed C1 was not treated with respect when nursing assistant (NA)-A came into C1's room, and repeatedly stated, "come on, come on" to get C1 to get up out of bed. NA-A stated to tap C1's right shoulder repeatedly. When C1 sat up in the bed NA-A put C1's shoes on. C1 stood by the edge of the bed and NA-A stood approximately six feet away from her, next to the walker with C1's comb, NA-A did not say anything, and waved the comb at C1 and pointed to C1 with the comb and then to the walker and said, "What are you doing (short pause) today junior". NA-A abruptly pushed the walker toward C1 and began to brush her hair, C1 stated, "why don't you leave me alone", and NA-A replied,	0 090		

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0 090	Continued From page 6 "because you don't listen, you don't want to go for dinner, you don't, you don't, you don't". Review of video recording dated October 21, 2013 revealed C1 was not treated with respect when NA-A assisted C1 to get dressed and stated, ""You are really frustrating; you know that, that is why I am so rough with you. Put your shirt on". NA-A quickly put C1's shirt over her head and walked into the bathroom. NA-A walked out of the bathroom and back to C1. While NA-A assisted C1 with her shirt sleeves NA-A stated loudly to her, "Don't you know how to put a shirt on, you are the slowest person; and you know that, it takes you 10 hours to put a shirt on; pull your pants down". C1 did not pull her pants down and NA-A bent down and pulled C1's pants down. NA-A stood up, and while standing over C1 looking down at her, NA-A stated in a louder voice, "you don't listen to me, you don't do what I tell you to do, I have to be forceful because you don't want to do anything, ever" (emphasized). NA-A walked away and stated to the client, "you just stand around, you try and get out of everything, you are like a child but you're not, you're a grown ass adult." NA-A then turned her back towards C1 and pointed her finger and stated, " that is what you are, a grown ass adult. NA-A stated to the C1,"stand up, pull your pants up, I should just make a poster and wave it in front of your face". C1 stated, "Well, you are in a good mood this morning." NA-A replied as she walked away from C1, "Ya, ya I am, or I was until I came here." NA-A then instructed C1 to sit down on a chair so NA-A can make her bed, C1 replied, "I can make my own bed." NA-A replied loudly, "No, you never do things" and C1 replied, "what do I say that I don't do?" NA-A replied in a argumentative, loud tone , "Everything, oh, I will make my bed, I'll get up, I'll take a shower, you're	0 090		

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0 090	Continued From page 7 like a child and I already have one child, I don't appreciate having to take care of adult children". During and interview with NA-A on 2/24/14 at 10:20 a.m.., NA-A denied yelling or hitting the C1; however, NA-A did admit that she was loud and forceful with the C1 because C1 does not listen. NA-A stated that she did tap C1's legs but she never hit her. NA-A said she understands dementia but that C1 did stuff just to get out of doing things. NA-A stated that C1 needed NA-A to be stern and forceful because of her illness. NA-A denied that any of her actions that day were abusive. NA-A stated that she received training from the facility regarding dementia and how to care for clients with dementia. NA-A reported that the facility provided instructions on what to do if the NA's started to feel frustrated with an individual client. NA-A acknowledged that she was frustrated with C1 that day (10/23/2013) and should have probably discussed this frustration with her supervisor. NA-A described C1 as someone that said no to everything, the day would start with C1 saying no to get out of bed, no to going to breakfast and so on. NA-A stated that C1 consumed a lot of NA-A's day because they would have to go in and if she refused something they would have to go back in and approach her again. Time Period for Correction: Thirty (30) days	0 090		
0 095	144A.44 Subd.1(15) Free from abuse Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 095		

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	H27800	A. BUILDING: _____ B. WING _____	C 04/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS	3451 PARKLAWN EDINA, MN 55435

(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
0 095	Continued From page 8 (15) the right to be free from physical and verbal abuse; This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure that clients were free from abuse for 1 client (C1) of 1 clients. Review of C1's medical record revealed the client was admitted to the facility on on 1/30/2012 with diagnoses that included vascular dementia. Review of C1's service plan agreement, effective date 4/29/13 identified C1 requiring assistance with activities of daily living (ADL) including dressing/undressing. grooming, medication administration, toileting and escorting to and from meals and activities. Review of video recording dated October 21, 2013 revealed that Nursing Assistant A (NA-A) entered the C1's apartment and announced that it was time for lunch, C1 was supine in bed, and NA-A repeatedly stated, "come on, come on" to C1. NA-A spoke louder, "come on, come on" and started to tap the C1's right shoulder repeatedly. NA-A then began to tap the C1's right inner thigh. NA-A leaned over C1 while C1 was lying in bed, braced herself with hands on the bed and C1 rolled to the left side, away from NA-A and covered her face with her arm. C1 then lifted her right leg to block NA-A's right hand from tapping her shoulder. NA-A was observed to grab C1's right ankle and pull on her pants. C1 loudly stated, "stop it; you are going to bruise me". NA-A	0 095		

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0 095	Continued From page 9 started to pull on C1's shirt and the elastic in the pants, then placed both hands on C1's right hip and pushed down so C1 rocked back and forth on the bed. C1 sat up in the bed and NA-A then put C1's shoes on. C1 stood by the edge of the bed and NA-A stood approximately six feet away from her, next to the walker with C1's comb, NA-A did not say anything, and waved the comb at C1 and pointed to C1 with the comb and then to the walker and said, "What are you doing (short pause) today junior". NA-A abruptly pushed the walker toward C1 and began to brush her hair, C1 stated, "why don't you leave me alone", and NA-A replied, "because you don't listen, you don't want to go for dinner, you don't, you don't, you don't". As NA-A said this she walked back into the bathroom and put the comb away. When NA-A came out of the bathroom C1 had started to walk towards a chair in the room and NA-A quickly took hold of her left arm and they quickly exited the room while C1 held her walker. Review of video recording dated 10/23/13 revealed NA-A stood in front of C1 as C1 sate on the edge of her bed. NA-A stated, "take off your shirt", as C1 started to lay back down. NA-A took hold of the C1's right arm and pulled her back up to a sitting position and took her pajama shirt off. While putting the C1's bra on NA-A stated in a matter of fact tone, "You are really frustrating; you know that, that is why I am so rough with you. Put your shirt on". NA-A then quickly put C1's shirt over her head and walked into the bathroom. While in the bathroom NA-A said loudly, "stand up when you are done." C1 sat on the edge of the bed, looked at the shirt and looked around. NA-A walked out of the bathroom and back to C1. While NA-A assisted C1 with her shirt sleeves NA-A stated loudly to her, "Don't you know how to put a shirt on, you are the slowest person; and	0 095		

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0 095	Continued From page 10 you know that, it takes you 10 hours to put a shirt on; pull your pants down". C1 replied, "What are you doing, I guess I don't know". C1 did not pull her pants down and NA-A bent down and pulled C1's pants down. NA-A stood up, and while standing over C1 looking down at her, NA-A stated in a louder voice, "you don't listen to me, you don't do what I tell you to do, I have to be forceful because you don't want to do anything, ever" (emphasized). NA-A walked away and stated to the client, "you just stand around, you try and get out of everything, you are like a child but you're not, you're a grown ass adult." NA-A then turned her back towards C1 and pointed her finger and stated, " that is what you are, a grown ass adult. You don't have to come out for breakfast because it is too late so you will have to come out for lunch". Then NA-A stated to the C1,"stand up, pull your pants up, I should just make a poster and wave it in front of your face". C1 stated, "Well, you are in a good mood this morning." NA-A replied as she walked away from C1, "Ya, ya I am, or I was until I came here." NA-A then instructed C1 to sit down on a chair so NA-A can make her bed, C1 replied, "I can make my own bed." NA-A replied loudly, "No, you never do things" and C1 replied, "what do I say that I don't do?" NA-A replied in a argumentative, loud tone , "Everything, oh, I will make my bed, I'll get up, I'll take a shower, you're like a child and I already have one child, I don't appreciate having to take care of adult children". During and interview with NA-A on 2/24/14 at 10:20 a.m.., NA-A denied yelling or hitting the C1; however, NA-A did admit that she was loud and forceful with the C1 because C1 does not listen. NA-A stated that she did tap C1's legs but she never hit her. NA-A said she understands dementia but that C1 did stuff just to get out of	0 095		

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0 095	Continued From page 11 doing things. NA-A stated that C1 needed NA-A to be stern and forceful because of her illness. NA-A denied that any of her actions that day were abusive. NA-A stated that she received training from the facility regarding dementia and how to care for clients with dementia. NA-A reported that the facility provided instructions on what to do if the NA's started to feel frustrated with an individual client. NA-A acknowledged that she was frustrated with C1 that day (10/23/2013) and should have probably discussed this frustration with her supervisor. NA-A described C1 as someone that said no to everything, the day would start with C1 saying no to get out of bed, no to going to breakfast and so on. NA-A stated that C1 consumed a lot of NA-A's day because they would have to go in and if she refused something they would have to go back in and approach her again. TIME PERIOD FOR CORRECTION: Thirty (30) days	0 095		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up
PUBLIC DATA

Facility:
York Gardens
3451 Parklawn
Edina, MN 55435
Hennepin County

Report #: HL27800003

Date: June 18, 2014

Date of Visit: June 16, 2014
Time of Visit: 11:00 a.m.

By: Stephanie Richard, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up four state licensing order(s) which were issued on April 21, 2014, as the result of an investigation which had been completed on April 8, 2014.

The status of each order is as follows:
1 144A.44 Subd.1(2) - Corrected
2 144A.44 Subd.1(13) - Corrected
3 144A.4 Subd.1(14) - Corrected
4 144A.44 Subd.1(15) - Corrected

xc: Minnesota Department of Health – Licensing and Certification

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H27800	A. Building B. Wing	6/16/2014

Name of Facility	Street Address, City, State, Zip Code
YORK GARDENS	3451 PARKLAWN EDINA, MN 55435

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 06/16/2014	ID Prefix 00085 Reg. # 144A.44 Subd.1(13) LSC	Correction Completed 06/16/2014	ID Prefix 00090 Reg. # 144A.44 Subd.1(14) LSC	Correction Completed 06/16/2014
ID Prefix 00095 Reg. # 144A.44 Subd.1(15) LSC	Correction Completed 06/16/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ Reviewed By State Agency	Date:	Signature of Surveyor:	Date:
Reviewed By _____ Reviewed By CMS RO	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/8/2014	_____	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO