DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Fridley Assisted Living LLC			**Report Number:** HL27980005	**Date of Visit:** July 13 and 19, 2017
Facility Address: 6352 Central Avenue			**Time of Visit:** 8:30 a.m. to 4:00 p.m. 1:30 p.m. to 5:15 p.m.	**Date Concluded:** November 9, 2017
Facility City: Fridley			**Investigator's Name and Title:** Kathleen Smith, DNP, RN, PHN, Special Investigator	
State: Minnesota	**ZIP:** 55432	**County:** Anoka		

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was abused when staff/alleged perpetrator restrained the client in his/her room and blocked the door.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when the alleged perpetrator (AP) confined the client in the client's room by placing a chair outside the door and tying the chair to the doorknob with a transfer belt.

The client received services from the home care provider, including assistance with activities of daily living, medication administration, and assurance and redirection when confused. The client had a dementia diagnosis and experienced increased agitation and confusion in the evening. The client tended to wander in other clients' rooms at times, but was not considered a threat to others according to the clients' Vulnerability Assessment and Prevention Plan.

The home care provider staffed one direct care staff on each area during the overnight shifts. One night shift, when the AP was working in the area on which the client resided, the AP asked a staff member from another area to assist with the client, because since the client was coming out of his/her room and entering other clients' rooms. The other staff member suggested some redirection options to the AP. Sometime later, the other staff member heard screaming and banging, and upon locating the sound, found that the door to the client's room was secured with a chair under the knob of the door, with a transfer belt tied to

the doorknob and chair, preventing the door from opening. The client was inside the room and unable to exit. The staff member took a picture of the door, which was later shown to the home care provider's nurse and housing manager. The staff member then untied the chair from the doorknob, opened the door, and observed the client by the door shaking and crying, stating s/he was looking for his/her spouse. The client also stated somebody was trying to get him/her. The staff member comforted the client, and then went to find the AP. The AP stated none of the redirection options were effective with the client, and the AP did not know what else to do. A Registered Nurse assessed the client and did not identify any injuries.

Two administrative staff interviewed the AP regarding the incident. The AP stated the client was confined to the room due to behaviors and the AP's fear the client would get hurt. The home care provider terminated the AP's employment immediately, and provided reeducation to other staff regarding behavioral techniques to implement with clients with cognitive impairment, and issues around maltreatment and reporting.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

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 alleged perpetrator (AP) is responsible for the abuse. The home care provider had provided education to the AP regarding the Vulnerable Adults Act and maltreatment reporting, the Home Care Bill of Rights, communication skills and dementia, and behavioral expressions with dementia. The AP nonetheless decided to confine the client.

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 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 for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

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

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

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:

(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.

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.

The Investigation included the following:

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

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: One

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, 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: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: One

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
July 14, 2017		July 21, 2017		July 25, 2017	10:30 a.m.

If unable to contact was subpoena issued: ◉ Yes, date subpoena was issued August 29, 2017 ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services
☒ Use of Equipment
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Meals
☒ Facility Tour

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: Home care provider staff

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Fridley Police Department

Anoka County Attorney

Fridley City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8181

October 23, 2017

Ms. Lisa Shock, Administrator
Fridley Assisted Living LLC
6352 Central Avenue
Fridley, MN 55432

RE: Complaint Number HL27980005

Dear Ms. Shock :

A complaint investigation (#HL27980005) of the Home Care Provider named above was completed on August 25, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

John Aglieco
Health Program Representative-Senior
Minnesota Department of Health
85 East Seventh Place, Suite 220
PO Box 64970
St Paul, MN 55164-0970
Office 651-201-4212 Fax: 651-281-9796

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Enclosure

cc: Home Health Care Assisted Living File
Anoka County Adult Protection
Office of Ombudsman
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27980	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIDLEY ASSISTED LIVING LLC	6352 CENTRAL AVENUE FRIDLEY, MN 55432

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order is issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On July 13, 2017, a complaint investigation was initiated to investigate complaint #HL27980005. At the time of the survey, there were 56 clients receiving services under the comprehensive license. The following correction order is issued.	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 Nursing Homes. 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 and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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.	
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clients were free from maltreatment (abuse) for one of one clients (C1) reviewed, when a staff member confined C1 to his/her bedroom by placing as chair underneath the doorknob and tying the chair to the doorknob with a transfer belt. This practice resulted in a level 3 violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and is issued at an isolated scope when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 began receiving services in early 2014, with diagnoses of senile dementia and osteoarthritis. C1's Service Agreement, effective January 1, 2017, indicated C1 received redirection and reassurance during times of confusion, medication administration, bathing assistance, and every two hour safety checks. Additionally, according to this document, C1 was able to propel his/herself by wheelchair. A Nursing Assessment dated April 3, 2017, indicated C1 often had increased confusion, anxiety, and agitation later in the evening, requiring redirection	0 325		

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0 325	Continued From page 2 by staff. The Vulnerability Assessment and Prevention Plan dated April 19, 2017, indicated C1 did not pose a threat to others. A review of the facility investigation document written by Registered Nurse (RN)-K, dated June 12, 2017, indicated Unlicensed Personnel (ULP)-E, reported finding, at approximately 3:30 a.m. that morning, that the bedroom door for C1 had been blocked by ULP-J with a chair, and the door knob was tired to the chair with a transfer belt. During an interview on July 19, 2017, at 3:24 p.m., ULP-E stated that ULP-J had requested assistance with C1 earlier during the shift, as C1 continuously went from room to room. ULP-E stated that later, ULP-E heard screaming and banging on the door, and determined it was coming from C1's room. At that time, ULP-E noticed there was a transfer belt tying a chair to the doorknob. ULP-E took a picture of how the door was secured, and showed the picture during the interview. ULP-E stated upon opening the door, C1 was sitting in the wheelchair shaking and crying. C1 stated s/he was looking for her/his spouse. C1 also stated someone was trying to get [him/her]. ULP-E comforted C1, and then reported the incident. During an interview on July 19, 2017, at 4:20 p.m., the Housing Manager (HM)-A stated that when ULP-J was asked about the incident, ULP-J stated C1 was confined to the room on June 12, 2017. During an interview on July 19, 2017, at 2:47 p.m.,, Registered Nurse (RN)-K, stated that during her interview of ULP-J, ULP-J stated that C1's door had been secured with a chair and	0 325		

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0 325	Continued From page 3 transfer belt. Review of the licensee's Policy 01-105, titled Dementia Training and Disclosure Requirements, last review date November 14, 2016, indicated staff receive training in the management of clients with dementia. Policy number 02-302.13 last reviewed November 14, 2016, revealed staff receive training in how to communicate with clients with dementia prior to providing any service to clients. Time Period for Correction: Twenty-one (21) Days	0 325		