Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306848265M
Compliance #: HL306845482C

Date Concluded: September 20, 2023

Name, Address, and County of Licensee Investigated:
Brookdale West St Paul
305 Thompson Avenue East
West St. Paul, MN 55118
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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) emotionally abused a resident when he made a threatening statement to the resident after another staff member found the resident's medications in a Kleenex box.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The staff member who witnessed the encounter said the AP did not make threatening comments to the resident. There was not enough information to determine if the AP's actions of grabbing the resident's face to administer medications constituted abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records and employee files. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included memory loss, anxiety, and heart disease. The resident's service plan included assistance with dressing, grooming, bathing, toileting, medications, and meals. The resident's nursing assessment indicated the resident had memory loss and was not aware of the time or her surroundings. The resident was alert but orientated to herself only and had difficulty communicating her needs.

The facilities incident investigation summary indicated an unlicensed staff personnel (ULP #1) told management ULP #2 told her, she found the resident's medications in a Kleenex box and brought them to the AP who then approached the resident, grabbed her cheeks in a rough manner and said directly to her, "You know what happens in my country when someone doesn't take their medicine, they get beat."

During an interview, ULP #1 said ULP #2 told her the AP went to the resident, grabbed her by the mouth and said, "You know what we do to our women in our country? We smack them in their mouth." ULP #1 told ULP #2 to report the incident to management, but she ended up telling management what she heard from ULP #2. ULP # 1 said she was unaware when the incident occurred or how much time had passed from when the incident happened, until ULP #2 told her about it. ULP #1 said she was not working at the time of the incident and heard about the incident from ULP #2 after it occurred.

During an interview, ULP #2 said she was working in memory care as a caregiver while the AP was working as a medication aide. ULP #2 said she observed the AP grab the resident, pull her closer to him, grab her cheeks, and "stuff" pills in her mouth. The resident then spit out the pills. ULP #2 said she told the AP to take his hands off her. ULP #2 said the resident appeared uninjured. ULP #2 said in response the AP made a comment about slapping women in his country when women do not do something. ULP #2 said the AP directed to comment toward her, and not the resident. ULP #2 said the resident was behind her when the AP made the comment. ULP #2 said she continued to work with the AP for the evening and there were no further negative interactions. ULP #2 said the AP did not appear angry at the time of the incident.

During an interview, a manager said the facility nurse reported the incident to her two days after it occurred. The manager said she suspended the AP and conducted an investigation to determine what happened. The manager said she saw the resident who appeared to be uninjured. The manager said the resident was unable to tell her what happened because she had advanced memory loss. The manager said she spoke to the AP, and he told her at the time of the incident he was having a hard time giving the resident her medications and she spit them out into a tissue box. The manager said the AP admitted he put his hands on the resident's cheeks to hold her face in place and put the medication in her mouth. The AP told her he was talking with another caregiver about the incident and how in his country (homeland) they treat people badly rather than how things are done in America. The manager said the AP denied

saying those comments to the resident but admitted to putting his hands on her face to keep her still.

During an interview, the facility nurse said she was unaware of the incident until after the AP no longer worked at the facility. The facility nurse noticed the AP was no longer on the schedule and was unsure why. The nurse said management told her they investigated an allegation of abuse and found no wrongdoing. The facility nurse said she worked with the AP prior to the incident and never had any concerns over his work performance.

During an interview, the AP said he was working at a facility building when a manager asked him to leave his location and go to the memory care building to administer medications because they were short of staff. The AP said it was his first-time administering medications in memory care. The AP said the manager told him there would be someone there to introduce the residents to him, however ULP #2 was not helpful. The AP said he gave the resident her medication and as he turned around another worker (ULP #3) told him she was spitting them out, so he put his hand under her chin to catch the medication. The AP denied squeezing the resident's cheeks. The AP said he did not grab the resident's face or restrict her movement. The AP said he did not make threatening comments to the resident. The AP said after the incident, he was talking with another worker (ULP #4) who was also from a different country about their homelands. The AP said their conversation occurred while they were sitting in a different location apart from the resident. The AP said ULP #2 must have been listening to their conversation.

ULP #3 and ULP #4 were not identified because staff floated between the two buildings. The facility investigation lacked statements or identification of other staff who worked in memory care at the time of the alleged incident.

During an interview, a family member said they were not aware of the incident. The family member said they felt the resident received good care and did not have concerns with the facility.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

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:
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: No. Memory loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided re-education to staff members and investigated the allegation.

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.

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
	30684	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL MC	315 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118

(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: #HL306845482C/#HL306848265M On September 7, 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 fourteen residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306845482C/#HL306848265M, tag identification 650, 1760.	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.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 1 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees unlicensed personnel (ULP)-C and ULP-G) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-C was hired on October 21, 2022. ULP's employee filed lacked any competency evaluations. On September 7, 2023, at 9:30 a.m., executive director (ED)-F said employee files are kept off site, but some of the records were electronic because they use the program Relias for education. On September 13, 2023, ED-F provided competency evaluations for ULP-C. All the competency evaluations were dated as completed on September 12, 2023, one day prior to being given to surveyor. On September 13, 2023, at 2:32 p.m., surveyor sent ED-F an email regarding competency documentation completed prior to September 12, 2023. On September 13, 2023, at 3:01 p.m., ED-F responded, "Unfortunately, we could not find record of dementia or competencies for her." ULP- G was hired on September 19, 2022. ULP-G's employee file lacked documentation of dementia training. On September 18, 2023, at 2:06 p.m., ULP-G said he received dementia training online prior to working in memory care. ULP-G said the online training was orientation to work at the facility but also from a prior employer. Licensee's, Orientation and Annual Training Requirements MN-20, policy dated May 2018, revised August 2021, indicated evidence of employee training would be kept in the personnel file.	0 650		

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0 650	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication was administered as prescribed for one of one resident (R1) with records reviewed. Additionally, the licensee failed to ensure staff who administered medications were the same staff who documented the medication administration. 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	01760		

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01760	Continued From page 4 situation has occurred only occasionally). The findings include: R1 admitted to licensee's memory care unit for diagnoses including memory loss, anxiety, and heart disease. R1's electronic medication records (EMAR) dated December 1, 2022, through January 31, 2023, lacked documentation medications were administered. The medications were as follows: Melatonin: Give 6 milligrams (mg) by mouth at bedtime for insomnia. The EMAR lacked documentation the staff administered the medication on 12/1/22, 12/3/22, 12/4/22, 12/6/22, 12/21/22, 12/28/22, 1/3/23, 1/10/23, and 1/21/23. Mirtazapine 15 milligrams (mg) by mouth at bedtime for insomnia. The EMAR lacked documentation the staff administered the medication on 12/1/22, 12/3/22, 12/4/22, 12/6/22, 12/21/22, 12/28/22, 1/3/23, 1/10/23, 1/21/23. Quetiapine Fumarate ER Tablet 150 milligrams (mg) at bedtime for generalized anxiety disorder. The EMAR lacked documentation the staff administered the medication on 12/1/22, 12/3/22, 12/4/22, 12/6/22, 12/13/22, 12/21/22, 12/28/22, 1/3/23, 1/10/23, 1/21/23. Trazodone 200 milligrams (mg) at bedtime for insomnia. The EMAR lacked documentation the staff administered the medication on 12/1/22, 12/3/22, 12/4/22, 12/6/22, 12/13/22, 12/21/22, 12/28/22, 1/3/23, 1/10/23, and 1/21/23. On September 7, 2023, at 3:09 p.m., operation specialist (OP)-B said on December 12, 2022,	01760		

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01760	Continued From page 5 registered nurse (RN)- E told her unlicensed personnel (ULP)-C witnessed ULP-G squeeze R1's face while trying to administer medication on December 10, 2022. R1's EMAR dated December 1, 2022, through December 31, 2022, failed to identify any medications were administered under the initials for ULP-G. On September 12, 2023, at 11:35 a.m., executive director (ED)-F acknowledged the discrepancy in documentation, and said she was unsure why there would be a discrepancy. Licensee, Medication and Treatment, General Guidelines for medication administration/Assistance, policy dated November 2011, and updated September 2023, indicated medications would be administered as the physician ordered. The policy indicated staff who administered medication would document with their initial for each medication administered. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		