

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308371942M
Compliance #: HL308373668C

Date Concluded: April 24, 2023

Name, Address, and County of Licensee

Investigated:

The Brooks on St. Paul
2480 St. Paul Road
Owatonna, MN 55060
Steele County

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

Evaluator's Name: Michele R. Larson, 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 alleged perpetrator (AP) emotionally abused a resident when she locked the resident in his room during an overnight shift. Morning staff unlocked the resident's door and found the resident crying.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. Even though there was a master key to lock the resident's doors from the outside of their apartments, all residents were able to unlock their doors from the inside of their apartments by turning their door handles. Multiple staff stated the resident was able to open and close his door without staff assistance at the time of the incident. The AP stated she did not lock the resident in his room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's family member. The investigation included review of resident medical records, personnel records, including the AP's personnel record, and the facility's policies and procedures. The investigation included an onsite visit for observation of the facility's day to day activities.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with safety checks, wandering, and redirection. The resident's assessment indicated he was disoriented to person, place, and time due to his diagnosis of dementia. The resident lacked the cognitive ability to know how to use his call button for staff assistance.

One summer morning at 6:30 a.m., in the memory care unit, an unlicensed staff personnel (ULP 1) performed resident checks. When ULP1 went to open the resident's apartment door she found his door was locked. When ULP1 opened the resident's door, the resident cried and hugged ULP1, stating he was happy to see her because the "other one was mean." ULP1 immediately reported the incident to a memory care nurse.

During an interview, ULP2 stated the resident was always in and out of his apartment during the time of the incident and often mistook other resident's room as his.

During an interview, the AP stated the resident kept wandering into a male resident's apartment which across the hall from the resident. The other resident was visibly upset and frustrated by the resident was constantly in and out of his apartment. The AP stated she redirected and brought the resident back to his room and closed his door. The other resident locked his apartment door. The AP stated the resident followed her to the dining room immediately after she closed his apartment door. The AP stated the resident stayed in the dining room with her until 2:30 a.m. when he finally agreed to go back to his apartment. The AP stated ULP1 never liked her.

During an interview, the director of nursing (DON) stated the facility immediately conducted an internal investigation. The DON stated she contacted the facility's regional nurse for guidance who recommended she go and check the resident's door to ensure it was not locked from the inside of his apartment. The DON stated she was able to verify the resident's door was able to open. The DON she then spoke to the AP about the alleged incident. The AP told the DON she redirected the resident back to his apartment to separate the resident from the other resident. The AP told the DON the resident immediately followed her down the hall to the dining room after she brought him back to his apartment. The DON stated she believed the resident knew how to open his door at the time of the incident.

During an interview, the family member stated they were overall happy with the cares the resident received while he lived at the facility.

In conclusion, the Minnesota Department of Health determined emotional abuse was 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:

(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:

(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;

Vulnerable Adult interviewed: No. The resident was deceased at the time of the investigation.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility immediately conducted an internal investigation.

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: 30837	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2023
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NAME OF PROVIDER OR SUPPLIER THE BROOKS ON ST PAUL	STREET ADDRESS, CITY, STATE, ZIP CODE 2480 ST. PAUL ROAD OWATONNA, MN 55060
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING 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>#HL308373668C/#HL308371942M</p> <p>On March 23, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL308373668C/#HL308371942M, tag identification 1320, 1540, 1640.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing 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> <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>	
01330 SS=D	<p>144G.60 Subd. 4 (b) Unlicensed personnel</p> <p>(b) Unlicensed personnel performing delegated</p>	01330		

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

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01330	<p>Continued From page 1</p> <p>nursing tasks in an assisted living facility must:</p> <p>(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;</p> <p>(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or</p> <p>(3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed in all the required areas prior to providing assisted living services for one of four unlicensed personnel (ULP)-E with records 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>	01330		

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01330	<p>Continued From page 2</p> <p>ULP-E's personnel file was reviewed. ULP-E was hired May 9, 2022 to provide direct care services to residents under the licensee's assisted living with dementia care license.</p> <p>ULP-E's employee training records lacked evidence she successfully completed practical skills evaluations as required for training in the following areas:</p> <ul style="list-style-type: none"> -documentation requirements for all services provided - reports of changes in the resident's condition to the supervisor designated by the facility -appropriate and safe techniques in personal hygiene and grooming, including: -care and use of hearing aids -standby assistance techniques and how to perform them -medication, exercise, and treatment reminders -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -procedures to use in handling various emergency situations -awareness of commonly used health technology equipment and assistive devices <p>ULP-E's employee record lacked evidence of demonstrated competency or how the competency was assessed in the following areas:</p> <ul style="list-style-type: none"> -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -basic infection control, including blood-borne pathogens -maintenance of a clean and safe environment -appropriate and safe techniques in personal 	01330		

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01330	<p>Continued From page 3</p> <p>hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting -training on the prevention of falls -standby assistance techniques and how to perform them -medication, exercise, and treatment reminders -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -understanding appropriate boundaries between staff and residents and the resident's family -procedures to use in handling various emergency situations -awareness of commonly used health technology equipment and assistive devices</p> <p>On April 4, 2023, at 10:30 a.m., director of nursing (DON)-F stated she oversaw the nursing departments at both of the licensee's facilities. DON-F stated ULP training lasted seven days with on-the-floor training shadowing another ULP. After seven days ULP were signed off by a registered nurse (RN). DON-F stated the checklist was lengthy to ensure the ULP were competent in the skills they would be using on the floor.</p> <p>The licensee policy titled Personnel Records, dated August 1, 2021, indicated personnel files would include a record of all required training for unlicensed personnel and competency determinations.</p> <p>TIME PERIOD TO CORRECT: Twenty-one (21) days.</p>	01330		

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01540 SS=D	<p>144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED</p> <p>(3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four unlicensed personnel (ULP)-E received the required amount of dementia care training in the required time frame with employee records 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>	01540		
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01540	<p>Continued From page 5</p> <p>The findings include:</p> <p>The licensee had a current assisted living with dementia care license.</p> <p>ULP-E's personnel file was reviewed. ULP-E was hired May 9, 2022, to provide direct care services to residents under the licensee's assisted living with dementia care license.</p> <p>ULP-E's employee record lacked documentation to indicate ULP-E completed the required eight (8) hours of training on specific dementia care topics within the first 80 working hours of providing services for the licensee.</p> <p>On April 4, 2023, at 10:30 a.m., director of nursing (DON)-F stated ULP were trained by their home office education staff and an onsite registered nurse (RN).</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	01540		
01640 SS=E	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for</p>	01640		

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01640	<p>Continued From page 6</p> <p>Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two residents (R1, R2) with records reviewed received all of their scheduled services as indicated in their service plans.</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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1's medical record was reviewed. R1 admitted to the licensee's facility on September 30, 2021. R1's diagnoses included dementia, and malignant neoplasm of connective and soft tissue of thorax (chest).</p> <p>On October 1, 2021, hourly safety checks were implemented to R1's service plan.</p>	01640		
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01640	<p>Continued From page 7</p> <p>R1's registered nurse (RN) assessment dated March 14, 2022, indicated R1 was disoriented to person, place, and time. R1 wandered into other resident's rooms and did not understand boundaries. R1 had a history of elopement. Although R1 did not respond to redirection, staff were to frequently redirect R1 to avoid R1 eloping from memory care unit.</p> <p>R1's vulnerability assessment dated June 22, 2022, indicated R1 was unable to use his call button for staff assistance due to his diagnosis of dementia. Staff were to anticipate R1's needs and to follow his service plan.</p> <p>R1's service plan dated June 22, 2022, indicated R1 received assistance with personal cares, cueing/standby, compression stockings, medication management, toileting, behaviors including wandering and hourly safety checks.</p> <p>R1's service delivery record dated June 2022 indicated R1's hourly safety checks were not documented as provided as indicated in R1's service plan.</p> <p>R2 R2's medical record was reviewed. R2 admitted to the facility on July 19, 2021. R2's diagnoses included neurocognitive disorder without behaviors.</p> <p>R2's RN assessment dated February 15, 2023, indicated R2 was disoriented to person, place, and time. R2 ws unable to give consistent, accurate information due to dementia and had significant orientation concerns that required redirection. R2 wandered the halls at night.</p>	01640		

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01640	<p>Continued From page 8</p> <p>On March 20, 2023, R2's safety checks were increased to three times per day.</p> <p>R2's vulnerability assessment dated March 23, 2023, indicated R2 was unable to use her call button to call for staff assistance due to her diagnosis of dementia.</p> <p>R2's service plan dated March 23, 2023, indicated R2 received assistance with personal cares including twice weekly assistance with bathing, weekly housekeeping, medication management four times per day, meals, safety checks, daily orienting to time and place, and behaviors, including wandering.</p> <p>R2's service delivery record dated March 2023, indicated R2's safety checks and housekeeping were not documented as provided as required in her service plan on the following dates: *Weekly housekeeping: March 16 and 23, 2023 *Safety Checks three times per day: March 20 through March 23, 2023</p> <p>On March 31, 2023, at 9:00 a.m., RN-C stated she and director of nursing (DON)-F developed the resident's service plans. RN-C stated ULP followed resident service plans and used work lpads to see what services residents needed at specific times.</p> <p>The licensee policy titled Service Plans, dated August 1, 2021, indicated all assisted living residents had an up-to-date service plan that identified services to be provided based on the assessment by the RN or other licensed health professional. The facility would implement and provided all services required by the current service plan unless unable for reasons such as resident refusal.</p>	01640		

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01640	Continued From page 9 TIME PERIOD TO CORRECT: Seven (7) days.	01640		