

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL327306884M
Compliance #: HL327302995C

Date Concluded: September 7, 2023

Name, Address, and County of Licensee

Investigated:

The Stanton House with Services Inc
4847 Bryant Avenue North
Minneapolis, Minnesota 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The alleged perpetrator (AP) abused a resident when the AP hit the resident across the face. Additionally, the facility neglected the resident when the facility failed to provide proper catheter care.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. Although the resident stated he was hit across the face, all staff interviewed denied any abuse towards the resident, and facility documentation did not indicate the incident occurred. The resident denied having pain or marks on his face from the alleged incident.

The Minnesota Department of Health determined neglect was not substantiated. Although the resident admitted to the emergency room (ER) multiple times, hospital records identified the resident as being at risk for recurrent urinary tract infections (UTI's) due to his surgical bladder procedure. The facility staff followed catheter orders and administered antibiotics as ordered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member and law enforcement. The investigation included review of the resident's medication administration record, assessments, care plan, and service delivery records. Staff schedules, personnel files and facility policies were also reviewed. The investigator toured the facility and observed interactions between staff and residents, and resident catheter care.

The resident resided in an assisted living facility. The resident's diagnoses included quadriplegia (paralysis below the neck that affects all limbs), anoxic brain injury (lack of oxygen to the brain), and neurogenic bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). The resident's service plan included assistance with medication administration and catheterization. The resident's assessment identified the resident as needing total assistance from staff with cares and identified the resident as having inappropriate behaviors directed towards staff.

Abuse Allegation

The resident's progress notes indicated numerous episodes of verbal and physical abuse towards the staff from the resident. The progress notes did not include documentation of the incident.

The facility did not complete an incident report.

Personnel files indicated appropriate Abuse and Neglect and Vulnerable Adult training.

Law enforcement records did not indicate a reported incident related to this alleged incident.

During investigative interviews, multiple staff members stated the resident displayed behaviors of being verbally and physically abusive to staff, including hitting and kicking. During interviews, no staff stated they witnessed abuse of the resident.

During an interview, the resident stated the AP hit him in the face during a shower. The resident stated multiple people were in the bathroom when it occurred. The resident denied having any pain or marks to his skin after the incident. The resident denied feeling afraid.

During an interview, the AP stated she did not abuse to the resident. The AP stated the resident has hit her and called her names. The AP stated the resident often told staff he is going to call the state and get this place shut down.

During an interview, a family member stated he agrees with a move, but every place he goes, they put hands on him. He stated the resident has a history of abuse allegations at previous facilities he resided.

During an interview, an administrative staff member stated neither the resident nor staff ever reported any abuse towards the resident to her.

Neglect Allegation

The resident's service delivery record indicated staff performed catheter care as ordered, four times daily.

The resident's hospital record indicated a provider performed an infectious disease consult. The provider notes indicated the resident's symptoms were less likely to be from UTI.

During an interview, unlicensed personnel (ULP) stated the resident occasionally requested to have his catheter drained just a short time after they just drained it.

During an interview, a registered nurse (RN) stated the resident often requested to have his catheter drained more frequently than the provider order directed. She stated the resident became verbally abusive despite education on the risks and benefits of draining his catheter too often.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive. The Minnesota Department of Health determined neglect 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.

"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:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; Stop here if it is not a restraints issue or sexual abuse.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

Neglect means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

Facility followed the providers orders for catheterization and antibiotic administration.

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: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER 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>#HL327302995C/#HL327306884M</p> <p>On August 8, 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 five residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL327302995C/#HL327306884M, tag identification 510,720.</p>	0 000	<p>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 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>	
0 510 SS=D	<p>144G.41 Subd. 3 Infection control program</p> <p>(a) All assisted living facilities must establish and</p>	0 510		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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
0 510	<p>Continued From page 1</p> <p>maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to change gloves while performing catheter care for one of one residents (R1) 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> <p>The Center for Disease Control webpage titled Catheter-Associated Urinary Tract Infections, updated February 2017, indicated the standard practice for catheterization included perform hand hygiene, use appropriate antiseptic solution to cleanse the peri-urethral site, remove gloves, perform hand hygiene. Then set up the sterile field, apply sterile gloves, use appropriate</p>	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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
0 510	<p>Continued From page 2</p> <p>antiseptic lubricant for the catheter tip and insert.</p> <p>R1 admitted May 10, 2022. R1's diagnoses included quadriplegia, anoxic brain injury, and neurogenic bladder. R1's service agreement, not dated, indicated R1 received assistance with catheter and toileting care.</p> <p>R1's provider order for catheter care dated February 10, 2022, indicated R1 required catheterization and flush of umbilical catheter four times daily.</p> <p>Personnel records for unlicensed personnel (ULP)-D indicated she started working at the licensee June 29, 2023. ULP-D was trained by registered nurse (RN)-C to perform catheter care for the VA.</p> <p>During an observation on August 8, 2023, at 11:13 a.m., ULP-D applied clean gloves to catheterize R1. ULP-D then opened R1's door with her gloved hands. ULP-D returned to R1's bedside, and wearing the same pair of gloves, began to open the catheter packaging. ULP-D proceeded to catheterize R1. After ULP-D completed the procedure, ULP-D failed to remove her gloves prior to handing R1 his phone.</p> <p>Licensee-provided document Policy and Procedure for Catheterizing a Mitrofanoff Appendicovesicostomy and Condom Catheter dated May 11, 2022, lacked directive on glove use for the procedure.</p> <p>The licensee-provided competency Practical Skills Evaluation dated June 6, 2023, did not indicate the use of gloves for the procedure.</p>	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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
0 510	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 720 SS=F	<p>144G.43 Subd. 2 Access to records</p> <p>The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide requested necessary resident and staff records in a timely manner.</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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 admitted on May 10, 2022. R1's diagnoses included quadriplegia, anoxic brain injury, and neurogenic bladder. R1's service agreement, not dated, indicated R1 received assistance with catheter and toileting care.</p> <p>R1's provider order for catheter care dated</p>	0 720		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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
0 720	<p>Continued From page 4</p> <p>February 10, 2022, indicated R1 required catheterization and flush of umbilical catheter four times daily.</p> <p>During the onsite investigation August 8, 2023, at 10:25 a.m., the investigator requested the following documents from licensed assisted living director (LALD)-A:</p> <ul style="list-style-type: none"> - current resident roster - staff schedules for August 8, 2023, and June 18, 2023 through June 20, 2023 - current staff roster - vulnerable adult (VA) and catheter care policies - VA reports, incident reports, and grievances for the last three months - personnel files for LALD-A, unlicensed personnel (ULP)-B, and registered nurse (RN)-C. <p>In response to this request on August 8, 2023, at 10:25 a.m., LALD-A stated she would work on getting the documents.</p> <p>On August 8, 2023, at 1:29 p.m., LALD-A had not provided any documents. At this time, the investigator requested the following additional documents from R1's medical record to LALD-A:</p> <ul style="list-style-type: none"> - medication administration record (MAR) from June 2023 - signed individual abuse prevention plan (IAPP) - doctors orders - face sheet - signed service agreement - nurse notes from June 2023 to current - MAR June 2023 - last two most recent assessments 	0 720		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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
0 720	<p>Continued From page 5</p> <ul style="list-style-type: none"> - service delivery sheets from June 2023 - staff training and education from the last three months. <p>During an interview on August 8, 2023, at 2:03 p.m., LALD-A stated she would provide all the documents to the investigator the following day. LALD-A provided R1's face sheet and the current resident roster at this time. LALD-A did not provide any other requested documents.</p> <p>During email correspondence on August 8, 2023, at 3:46 p.m., LALD-A provided the requested policies, current staff roster, and staff schedules. This email did not include the rest of the requested documents or information on when to expect the rest of the documents.</p> <p>During email correspondence on August 9, 2023, the investigator emailed LALD-A at 8:32 a.m. and again at 6:06 p.m., due to not receiving the rest of the requested documents. The investigator also requested ULP-G's personnel record at 6:06 p.m. At 6:26 p.m., LALD-A sent an email questioning why the investigator requested ULP-G's record but did not send any documents.</p> <p>During email correspondence on August 18, 2023, the investigator sent an email at 11:06 a.m., requesting the personnel record for ULP-H, and another email at and 12:26 p.m., requesting policies regarding the complaint and investigation process, reporting maltreatment of a VA, medication management services, employment process, and personnel records. LALD-A sent separate emails addressing both these request emails at 1:04 p.m. and 1:05 p.m., indicating she would send the records Monday, August 21, 2023, as she was out of the office.</p>	0 720		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430
---	--

(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
0 720	<p>Continued From page 6</p> <p>During email correspondence on August 22, 2023 at 7:29 a.m., the investigator emailed to follow up on the requested documents, as they had not been sent on August 21, 2023. LALD-A responded at 8:08 a.m., indicating she had been out of the office but would send them the same day. LALD-A emailed documents at 12:17 p.m. At 2:00 p.m., the investigator emailed LALD-A, indicating incidents, VA reports, and grievances for the last three months still had not been received. At 2:05 p.m., LALD-A responded, indicating they did not have any grievances, and incidents were in resident progress notes. LALD-A asked the investigator where she would find the VA reports they have made. LALD-A did not send R1's progress notes.</p> <p>During email correspondence on August 24, 2023, at 12:44 p.m., the investigator emailed LALD-A, following up on R1's progress notes and provider order for catheterization. At 12:51 p.m., LALD-A responded, indicating she could not get the progress notes sent the same day, as she was out of the office. On August 25, 2023, at 2:51 p.m., LALD-A sent another email indicating she got as much done as she could and would send the remaining notes on August 28, 2023. Progress notes from January 2023 through June 2023 were received. The remaining progress notes were received August 28, 2023.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 720		