Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL344261161M
Compliance #: HL344261947C

Date Concluded: September 20, 2022

Name, Address, and County of Licensee Investigated:
Elk Ridge Alzheimer's Special
1700 Beam Avenue
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator, RN
Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 facility neglected residents when they failed to provide adequate supervision that resulted in resident #2 inappropriately touching resident #1.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware of previous incidents of resident #2 inappropriately touching residents and failed to implement adequate measures to protect resident #1 from being inappropriately touched.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records,

employee files, internal investigations, incident reports, and facility policies. The investigator toured the facility and observed interactions between residents and facility staff.

Resident #1 lived at the memory care facility for diagnoses that included Alzheimer disease, anxiety, and depression. Resident #1's service plan included assistance with dressing, bathing, grooming, toileting, and ambulation. Resident #1's service plan indicated resident #1 was orientated to name only. The physician's assessment indicated resident #1 was pleasantly confused and unable to answer complex questions.

Resident #2 lived at the memory care facility for diagnoses that included dementia with behaviors, delusions, and hallucinations. Resident #2's service plan included assistance with dressing and grooming. Resident #2's service plan indicated he had inappropriate sexual behaviors of touching other residents. Resident #2's service plan indicated he could communicate needs verbally and follow re-direction but required assist with decision making. Resident #2's nursing assessment indicated he becomes verbally and physically combative when redirected.

During an interview, the manager said resident #2's hands had been inside resident #1's pants and inappropriately touching resident #1. The manager said this was the typical behavior exhibited by resident #2. The manager said resident #2 attempted to take resident #1 into the bathroom that same evening. The manager said they were unaware if resident #2 was alone in the bathroom with resident #1. The manager said resident #2 had targeted other residents, but this was the first time the manager was made aware resident #1 had been touched. The manager said staff provided hourly checks to all residents as standard care but are unable to check residents more frequently. The manager said staff keep an eye on resident #2, and the best intervention was to have staff observe resident #2 in the common lounge area. The manager said all residents on the unit should have their doors locked including resident #2 because of prior incidents. The manager said resident #2's primary physician had been contacted after the incident, and orders were obtained for medication changes. The manager said a request had been made to obtain a referral for resident #2 to be seen by psychology.

During an interview, the facility nurse said resident #2 had made multiple attempts to take resident #1 to the bathroom after resident #2 had been seen touching resident #1 her under her clothing. The facility nurse said resident #1 was unable to recognize she had been taken advantage of by resident #2 because of confusion from advanced Alzheimer disease. The facility nurse said if staff are in the hallways, they observe resident #2 often and separate other residents from him. The facility nurse said that it was difficult to observe resident #2 because he walked the hallways and changed his location. The facility nurse said she had been new to the job and lacked the tools required for taking further action but did email the manager a description of the events that occurred. The facility nurse said resident #2's behaviors have continued, and staff have removed other females from him. The facility nurse said the staff continue to observe and check him frequently.

The facility's internal investigation indicated resident #2 was observed coming out of the bathroom with resident #1 and later that evening, resident #2 was observed to have his hands under resident #1's blouse. The facility nurse said she spoke to resident #2 about those inappropriate behaviors.

During an observation, resident #2 was observed sitting on a bench outside his room with the door to his bedroom unlocked and slightly opened. Other residents were observed to be moving throughout the hallway.

Resident #2's medical record indicated resident #2's primary physician ordered him to receive scheduled dosages of a new psychotropic medication. The facility received the order after a previous incident of sexually touching another resident, prior to the current allegation. Resident #2's medication administration record (MAR) did not have the medication listed to be given.

Resident #2's primary physician ordered a referral for psychology. Resident #2's record indicated there was no evaluation from psychology and no further actions were taken to follow up with psychology.

During an interview, the manager said resident #2 had not been evaluated by psychology and the manager was uncertain when he would be seen. The manager said resident #2's psychotropic medication order had not been transcribed and resident #2 had not received the medication the physician ordered.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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: No, due to cognitive deficit.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided education for staff.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	C 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(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 Initial comments ASSISTED LIVING PROVIDER LICENSING 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: HL344261947C/HL344261161M, HL344261449M/HL344262893C, HL344262509C On August 9, 2022, through August 10, 2022, 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 thirty-six residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL344261947C/#HL344261161M, tag identification 1760, 2310, and 2360	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 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	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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 licensee failed to ensure medications were administered as prescribed for one of two residents (R2) reviewed with medication administration. This practice resulted in a level three violation (a violation that harmed a resident'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 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). The findings include: R2's medical record was reviewed. The physician assessment dated August 2, 2022, indicated R2's diagnoses included dementia with behaviors, delusions, hallucinations, and major depressive disorder with psychotic symptoms.	01760		

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01760	Continued From page 2 R2's service plan dated August 9, 2022, indicated R2 received medication administration services. R2's service plan indicated he had a history of inappropriate sexual behaviors including touching other residents. R2's nursing assessment dated June 29, 2022, indicated R2 becomes verbally and physically combative when redirected. An email sent to the executive director (ED)-A indicated on May 1, 2022, staff observed R2 coming out of the bathroom with R1 and then later that evening R2 was observed with his hands under R1's shirt. During an interview on August 9, 2022, at 1:09 p.m., ED-A said R2 had these behaviors before, and this was the typical behavior he exhibits. ED-A said R2 continues to touch female residents and becomes angry when staff intervene. R2's Individual Abuse Prevention Plan dated May 4, 2022, indicated the physician was contacted for medication adjustments and a request was made for a psychology referral. R2's medical record included a new order from R2's physician dated May 3, 2022, prescribing Olanzapine (anti-psychotic medication) twice daily for agitation. R2's medication administration record dated August 9, 2022, failed to include the new order for Olanzapine twice daily for agitation. R2's annual medication assessment dated June 29, 2022, failed to include Olanzapine twice daily order during the medication review.	01760		

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01760	Continued From page 3 During an interview on August 11, 2022, at 2:53 p.m., with licensed practical nurse (LPN)- B, said R2's behavior had continued and there had been several incidences of him touching other female residents. LPN-B said R2 had verbal outbursts when staff intervene. During an interview on August 11, 2022, at 1:05 p.m., ED-A said the licensee failed to transcribe R2's Olanzapine medication order. ED-A said R2 never received Olanzapine as prescribed. The licensee's Medication Management policy dated September 26, 2021, indicated routine psychotropic medication audits would be completed. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement orders for a specialty consult for one of two residents (R2) reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	02310		

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02310	Continued From page 4 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). The findings include: R2's medical record was reviewed. R2 admitted on November 16, 2021. The physician assessment dated August 2, 2022, indicated R2's diagnoses included dementia with behaviors, delusions, hallucinations, and major depressive disorder with psychotic symptoms. R2's service plan dated August 9, 2022, indicated R2 received medication administration services. R2's service plan indicated he had a history of inappropriate sexual behaviors including touching other residents. R2's nursing assessment dated June 29, 2022, indicated R2 becomes verbally and physically combative when redirected. An email sent to the executive director (ED)-A indicated on May 1, 2022, staff observed R2 coming out of the bathroom with R1 and then later that evening R2 was observed with his hands under R1's shirt. During an interview on August 9, 2022, at 1:09 p.m., ED-A said R2 had these behaviors before, and this was the typical behavior he exhibits. ED-A said R2 continues to touch female residents. ED-A said R2 becomes angry when staff intervene. R2's nursing assessment dated June 29, 2022, stated R2's behaviors included touching and	02310		

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02310	Continued From page 5 flirting with female residents. The nursing assessment indicated that his behaviors were frequent. R2's Individual Abuse Prevention Plan (IAPP) dated May 4, 2022, indicated the physician was contacted for medication adjustments and a request was made for a psychology referral. The IAPP indicated R2 had behaviors of touching female residents and verbal outbursts. R2's physician order dated May 4, 2022, indicated R2 required a referral to psychology. R2's records lacked a psychology evaluation and further follow up with psychology services. During an interview on August 9, 2022, at approximately 1 p.m., ED-A, confirmed R2 was never evaluated by psychology and no appointment was scheduled. During an interview on August 11, 2022, at 2:53 p.m., with licensed practical nurse (LPN)- B, said R2 had continued touching other female residents. LPN-B said R2 had verbal outbursts when staff intervene. The licensee Vulnerability, Safety and Risk Assessment policy dated 2022, indicated the resident's assessment must include specific measures should be taken to minimize the risk or potential risk of maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 6 Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. R1 and R2 were neglected. Findings include: On September 20, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.	