

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL344261449M
Compliance #: HL34426893C

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: Willette Shafer, RN
Special Investigator

Finding: Not Substantiated

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 resident #1 and resident #2 when the facility failed to provide supervision to keep the residents safe.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Facility staff witnessed resident #2 push resident #1 and took immediate action to separate the residents and called emergency medical services for resident #1.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigation included review of residents' medical records, incident report, and facility policies. Also, the investigator toured the facility and observed interactions between residents and staff.

Both residents resided in an assisted living memory care unit. Resident #1's diagnoses included dementia and major depressive disorder. Resident #1's service plan included assistance with transfers, meals, grooming, medication management, and housekeeping. Resident #2's diagnoses include dementia and major depressive disorder. Resident #2's service plan included assistance with behavioral management, socialization, toileting, grooming, housekeeping, and medication management.

During an interview, a management staff member stated resident #2 pushed resident #1 because resident #1 was standing in front of the TV. The management staff member said resident #2 had a history of aggression at a previous facility but had not displayed aggressive behavior since living at the facility. The management staff member said resident #1 hit his head when he fell and transported to the hospital immediately. The management staff member said the incident was witnessed and there was always a staff member in the common area. The management staff member said interventions were implemented to prevent any similar occurrences in the future.

During an interview, a nurse said it was reported to her resident #1 stood in front of the TV when resident #2 became upset and pushed resident #1. Resident #1 fell, and the facility called emergency medical services. The nurse said resident #1 stayed in the hospital for a short period and returned to the facility. The nurse said resident #2 had not shown any aggression towards himself or other since his admission.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, resident #1 is deceased and resident #2 was unable to interview due to cognitive decline.

Family/Responsible Party interviewed: No, declined.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility completed education with all staff. The facility set up an appointment for resident #2, with his primary care provider and requested a medication review.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/10/2022
NAME OF PROVIDER OR SUPPLIER ELK RIDGE ALZHEIMER'S SPECIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Initial comments 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>HL344261947C/HL344261161M, HL344261449M/HL344262893C, HL344262509C</p> <p>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.</p> <p>The following correction orders are issued for #HL344261947C/#HL344261161M, tag identification 1760, 2310, and 2360</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 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.</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 subd. 1, 2 and 3</p>		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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01760	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>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.</p>	01760			

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01760	<p>Continued From page 2</p> <p>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.</p> <p>R2's nursing assessment dated June 29, 2022, indicated R2 becomes verbally and physically combative when redirected.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R2's medication administration record dated August 9, 2022, failed to include the new order for Olanzapine twice daily for agitation.</p> <p>R2's annual medication assessment dated June 29, 2022, failed to include Olanzapine twice daily order during the medication review.</p>	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	<p>Continued From page 4</p> <p>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>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.</p> <p>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.</p> <p>R2's nursing assessment dated June 29, 2022, indicated R2 becomes verbally and physically combative when redirected.</p> <p>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.</p> <p>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.</p> <p>R2's nursing assessment dated June 29, 2022, stated R2's behaviors included touching and</p>	02310			

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02310	<p>Continued From page 5</p> <p>flirting with female residents. The nursing assessment indicated that his behaviors were frequent.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310			
02360	144G.91 Subd. 8 Freedom from maltreatment	02360			

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02360	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p>	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.		