Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL344261683M
Compliance #: HL344269260C

Date Concluded: March 5, 2024

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: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 restrained the resident's arms which caused bruising and skin tears.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide interventions for staff to use with a combative resident, so staff resorted to restraining the resident's arms when providing incontinence cares. The facility had several recommended interventions which they did not communicate with the staff via the service plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident records, photos of the resident's injuries, the facility internal

investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident lived in an assisted living with memory care. The resident's diagnoses included traumatic brain injury, arthritis, and bilateral hearing loss. The resident's service plan included assistance with bathing, redirection of behaviors, dressing/undressing, safety checks, fall prevention, toileting, and medication administration.

Prior to admission, the resident's family provided information about the resident's history, likes, hobbies, and preferences, but the facility did not incorporate any of the information into the service plan for behavior interventions.

The resident's behavior assessments recommended several different interventions for staff, but the facility did not incorporate the information into the resident's service plan.

The resident's service plan directed staff to "re-direct, monitor, and report" the residents' behaviors.

An incident report indicated one night the AP held down the resident's arms while changing the resident's incontinence brief because the resident was combative. The resident received bruises and two large skin tears on her arm as a result. The report indicated staff notified the on-call nurse.

During an interview, the nurse stated staff often had difficulty redirecting the resident. The nurse stated the facility did not require staff read the new resident information about likes, hobbies, and preferences. The nurse stated the recommended interventions should be in the resident's service plan. The nurse stated the AP and another staff each held down one of the resident's arms while changing her, to keep themselves safe from the resident. The nurse stated she did not consider their actions a restraint.

During investigative interviews, multiple staff members stated the facility did not provide interventions specific to the resident and reported they typically had to come up with interventions on their own.

During an interview, the AP stated the resident was aggressive at night and staff had difficulty changing the resident's incontinence brief because the resident would punch and kick at them. The AP stated the resident would not listen to her on the night of the incident. The AP stated her coworker held the resident's arms down on the night of the incident, while the AP quickly changed and cleaned up the resident. The AP stated the facility gave no direction on how to deal with the resident, leaving it up to staff to figure it out. The AP stated it was common practice to hold down the resident's arms/hands if the resident was hitting out.

During an interview, the other staff working on the night of the incident stated she normally held the resident's hands to prevent her from hitting. The staff stated on the night of the incident the resident was moving around a lot, trying to get loose from her hold. The staff stated she did not intentionally harm the resident, but the resident ended up with skin tears that were bleeding.

During an interview, a family member stated the resident was very hard of hearing and got frustrated when she did not know what was going on.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"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 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:
The facility changed the resident's services to include assistance of two staff for toileting.
The facility re-educated the AP and staff involved in the incident on recommended interventions for the resident.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
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 02/14/2024

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 ******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: #HL344269260C/ #HL344261683M On February 14, 2024, 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL344269260C/#HL344261683M, tag identification 1290, 1640, 2360.	0 000		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 1 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-E) reviewed received a Department of Human Services (DHS) clearance on their background study prior to providing direct contact services or access to residents. This had the potential to affect all 45 residents of the facility. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: The licensee hired ULP-E on August 1, 2022, to provide direct contact services to residents. A review completed on February 13, 2024, of the DHS background study website	01290	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. 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	

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01290	Continued From page 2 (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) indicated ULP-E did not have a background study clearance. The DHS background study website indicated the licensee submitted a background study request for ULP-E on July 28, 2022, and May 16, 2023. The website indicated the requests were closed on August 12, 2022, and May 31, 2023, due to "consent and disclosure not completed." The website indicated ULP-E required supervision. During an interview on February 14, 2024, at 12:28 p.m. assisted living director (ALD)-B stated the facility became aware that ULP-E did not have a cleared background study sometime between when an incident occurred with a resident (R1) on January 23, 2024, and February 14, 2024. ALD-B stated they removed ULP-E from the schedule until her background study cleared. The Background Study policy dated February 13, 2024, indicated no employee may provide direct services and have independent direct contact with any resident until acceptable result of the background study had been received. TIME PERIOD FOR CORRECTION: Two (2) Days	01290	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 SUBDIVISION 1-3.	
01640 SS=I	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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. (b) The service plan and any revisions must include a signature or other authentication by the	01640		

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01640	Continued From page 3 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 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to revise the service plan to include behavior interventions and failed to ensure staff used recommended behavior interventions for one of one resident (R1) reviewed for maltreatment. Harm occurred during a behavioral episode, when staff restrained R1's arms while changing R1's incontinence brief causing bruises and two large skin tears. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01640	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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH	

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01640	Continued From page 4 Findings include: R1 lived in the assisted living with dementia care facility since March 16, 2023, due to diagnoses that included traumatic brain injury, arthritis, glaucoma, and bilateral hearing impairment. R1's New Resident Alert document (undated and located in a binder behind the nurse's station) indicated R1 was married and had two daughters. The document indicated R1 was a talented oil painter, who loved traveling, the Minnesota Twins, cats, and going for walks. R1's record did not incorporate any of the information from the document in behavior interventions. R1's Behavior document (undated and located in a binder behind the nurse's station) indicated a behavioral health case manager visited R1 monthly. The document recommended the following interventions: May 30, 2023: "Take your time and don't rush [R1] during cares. Tell her step by step what you need to do and allow her to process before taking the next step. Give [R1] space when she needs it. Help [R1] spend time out of her room to enhance her mood. Allow [R1] to help with as much as she can during cares." July 19, 2023: "Set [R1] up with a fidget activity to keep her busy and engaged." R1's service plan did not contain the recommended interventions. R1's Vulnerability, Safety, and Risk assessment dated July 24, 2023, indicated R1 did not have the cognitive ability to report abuse or neglect. The assessment indicated R1's behaviors included biting, pinching, and kicking staff during cares. The assessment directed staff to "de-escalate and re-approach". The assessment	01640	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 SUBDIVISION 1-3.	

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01640	Continued From page 5 lacked direction on how to de-escalate. The assessment indicated planned interventions were located in the service plan. R1's progress note dated December 4, 2023, at 2:30 p.m. indicated a behavioral health case manager met with R1 and recommended staff offer R1 choices and independence whenever possible, as R1 told her she "feels like a child here being told what to do". The progress note indicated the behavioral health case manager recommended use of a pocket talker (a personal sound amplifier designed to help individuals with hearing difficulties by amplifying sounds while reducing background noise). R1's service plan did not contain the recommended interventions. R1's progress note dated January 7, 2024, at 3:26 p.m. indicated R1 was involved in a resident to resident altercation. The note indicated R1 got too close to a peer, they yelled at each other, and the peer slapped R1 across the face. R1's record did not contain an update to R1's service plan interventions. R1's progress note dated January 15, 2024, at 9:44 p.m. indicated R1 was having increased behaviors of hitting, punching, and slapping. R1's record did not contain an update to R1's service plan interventions. R1's incident report dated January 23, 2024, at 1:00 a.m. indicated ULP-D and ULP-E found R1 wet in bed and tried to change R1's brief, but R1 began hitting, punching, and slapping. The report indicated ULP-D and ULP-E were able to redirect R1 slightly, then held R1's hands/arms to apply a brief and provide peri-care. The report did not indicate R1 had an injury.	01640		

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01640	Continued From page 6 R1's incident report dated January 23, 2024, at 6:00 a.m. indicated ULP-F changed R1's bandage on a skin tear received earlier and noticed bruises on R1's arm as well as two large skin tears on her arm. The incident report provided no measurements of the skin tears. R1's progress note dated January 23, 2024, at 10:49 a.m. indicated R1 was combative with cares the previous evening. The note indicated unlicensed personnel (ULP)-E and ULP-D "were able to hold [R1's] arms to prevent them [ULP-E and ULP-D] from getting hit". The note indicated ULP-E noticed a skin tear and bruising on R1's right forearm. R1's record did not contain an update to R1's service plan interventions. R1's progress note dated January 25, 2024, at 4:21 p.m. indicated R1's behaviors were increasing, the doctor was notified, and the nurse requested an increase in R1's scheduled medication (Seroquel-an anti-psychotic medication). R1's record did not contain an update to R1's service plan interventions. R1's Service Plan dated January 31, 2024, indicated R1 received behavior management services which consisted of "redirection as needed, monitoring, and reporting behaviors to" the nurse. The service plan directed staff to utilize as needed medications (PRNs) and re-approach if combative with bedtime cares. R1's medication administration record (MAR) dated January 2024, listed the following non-medication intervention for restlessness/agitation prior to giving a PRN of Seroquel: companionship. R1's service plan did not contain this intervention.	01640		

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01640	Continued From page 7 R1's MAR dated February 2024, listed the following non-medication interventions for agitation prior to giving a PRN of Seroquel: redirection or music. R1's service plan did not contain these interventions. R1's nursing assessment dated February 8, 2024, indicated R1's frequent, combative behavior consisted of punching, kicking, biting, scratching, screaming, and pulling at clothing. The assessment directed staff to "redirect" R1. During an interview on February 14, 2024, at 9:35 a.m. ULP-G stated she had some techniques that she used with aggressive residents, such as talking to them to see what was wrong, giving them options, walking away, and trying later. ULP-G stated if a resident was punching, ULP-G would hold the resident's hands/arms to keep herself safe from the resident. ULP-G stated she developed her own strategies for the residents as she got to know them. ULP-G stated she was not aware of specific techniques for R1. During an interview on February 14, 2024, at 9:45 a.m. ULP-H stated she had general practices that she used with all residents who were aggressive, such as watching her own tone of voice, using music for some residents, or walking away and returning later. ULP-H stated she did not know if there were any practices specific to R1. During an interview on February 14, 2024, at 10:49 a.m. registered nurse (RN)-A stated R1 had aggressive behaviors. RN-A stated R1 was often not redirectable. RN-A stated staff had access to interventions in a binder behind the nurse's station and the medication administration record listed interventions to try before giving R1 a PRN. RN-A stated the recommended behavior	01640		

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01640	Continued From page 8 interventions should be in R1's service plan. RN-A stated that she understood that both ULP-D and ULP-E held down R1, one on each arm, but RN-A did not consider what they did a restraint. During an interview on February 14, 2024, at 12:28 p.m. assisted living director (ALD)-B stated recommended staff interventions to use with behaviors should be in R1's service plan, as that is what staff use to do their job. ALD-B stated staff should not have to search in various binders to find recommended interventions. During an interview on February 15, 2024, at 8:23 a.m. ULP-D stated R1 was always combative on night shift, so two staff would go in to assist her. ULP-D stated on the night of the incident, ULP-D held R1's arms down while ULP-E changed her brief and cleaned her up. ULP-D stated R1 was moving a lot while ULP-D held her arms down and she did not intend to hurt R1. ULP-D stated ULP-E put a bandage on R1's skin tear. During an interview on February 15, 2024, at 8:53 a.m. ULP-E stated R1 needed 3-4 people to change her brief. ULP-E stated she tried to calm R1 with her voice, but R1 would not listen. ULP-E stated she and ULP-D worked together to change R1 and took turns holding her arms or changing the brief. ULP-E stated the facility never provided them with direction for R1's aggression, and it was up to staff to figure out how to deal with R1. ULP-E stated it was common practice of staff to hold R1's arms down to change her brief. The Assessments, Reviews, and Monitoring policy dated February 13, 2024, indicated ongoing resident assessment and monitoring must be conducted as needed based on changes in the needs of the resident, not to exceed 90 days.	01640		

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01640	Continued From page 9 The Individual Abuse Prevention Plan policy dated February 13, 2024, indicated the plan contained an assessment of the resident's risk of abusing other vulnerable adults, and statements of the specific measures taken to minimize the risk of abuse. The Service Plan policy dated February 13, 2024, indicated service plans were based on outcomes of assessments and individual reviews of resident needs and preferences. The Vulnerable Adult Maltreatment policy dated February 13, 2024, indicated the licensee prohibited the maltreatment of vulnerable adults. The Vulnerable Adult policy dated February 13, 2024, defined abuse to include use of physical force that may result in injury, pain, or impairment including restraint by physical means. TIME PERIOD FOR CORRECTION: Seven (7) Days	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment 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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag	

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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
02360	Continued From page 10 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		