Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: #HL344266526M/ #HL344265383M

Date Concluded: July 19, 2023

Compliance #:
#HL344262254C/ #HL344269275C

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

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, individual 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), facility staff, abused resident #1 (R1), when the AP restrained R1's arms and hands to prevent the resident from moving. The AP abused resident #2 (R2) when the AP yelled at the resident resulting in R2 being fearful of the AP.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment for R1 and R2.
The AP was observed by three witnesses restraining R1's hands and wrists to prevent the resident's movement during medication administration.
The AP abused R2 when the AP failed to assist R2 according to the residents' individualized needs. The AP yelled at R2, pointed her finger in R2's face, and did not acknowledge R2's cries and requests for the AP to leave the resident's room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, camera footage, employee files, staff training, and facility policies and procedures. In addition, the investigator observed staff administration of medications.

R1 resided in an assisted living memory care unit with diagnoses including psychotic dementia and personal history of traumatic brain injury. R1's service plan included assistance with dressing, bathing, grooming, meals, housekeeping, laundry, and medication administration. R1's assessment indicated the resident had a history of anxious and aggressive behaviors.

A facility incident report indicated a facility employee reported to leadership she heard the AP tied R1's sweatshirt sleeves together so the resident could not get his hands out of his sweatshirt. The report indicated the staff member did not see the AP actually tie the sweatshirt, but the staff stated they observed the resident had his sweatshirt sleeves tied together. The report included statements from witnesses also working during the incident. One staff stated she witnessed the resident "yelling, screaming and swearing at the AP", and also, "saw the resident try to hit the AP multiple times and she [AP] brought him over to a chair and stood over him holding his [resident] arms or his hands down to stop him from trying to hit her". The staff stated she observed the resident fidgeting with his hands inside his sweatshirt sleeves, but she did not see the resident's arms tied in the sweatshirt. Another staff member reported, "I saw the AP was grabbing the resident forcefully by the wrists and he [resident] looked in pain and that is when he hit her, but she grabbed him again very forcefully". The staff stated she later saw the resident walking around after the incident and was crying. The staff stated she attempted to console R1, but he would not stop crying. Another staff member who witnessed the incident reported she saw the resident, "saying F-U to the AP, when the AP walked away, I saw the resident's hands tied up in his shirt, I came over and took the knot out of his shirt. He was also crying". The incident report indicated the AP was interviewed and stated, "the resident was very agitated and was attempting to hit me on several occasions. I held the resident's hands to prevent him from hitting others". The AP reported she sat with the resident long enough for the resident to get his medications, wait for them to take effect, and for the resident to settle down.

During interview unlicensed personnel stated she saw the AP yelling at R1. The staff stated she noticed R1 was crying, and his hands were tied in his sweatshirt sleeves. The AP walked away down the hallway and the staff stated she untied the tight knot in the sleeves of the resident's sweatshirt. The staff stated after she untied R1's sleeves, the resident walked off and another staff went to R1's room to help him get dressed. The staff member stated she went into R1's room to check on him and the resident continued to cry.

When interviewed the AP stated the resident was refusing to take his medication so she, "got in the resident's face a little," and told R1 he would need to take his medicine. The AP stated

when R1 attempted to hit her she grabbed R1's hand and held it, "like a handshake." The AP stated she sat with R1 on the couch until the resident took his medication and fell asleep.

R2 resided in assisted living memory care unit with diagnoses including dementia, anxiety, and chronic back pain. R2's service plan included assistance with activities of daily living, dressing, bathing, grooming, toileting, meals, laundry, housekeeping, and medication administration.

R2's abuse prevention plan indicated staff were to take their time with cares and anticipate the resident's needs. R2 had chronic pain and a history of hitting and kicking staff. Staff were directed to investigate what R2's s needs were, slow down, and allow the resident to do what she can on her own. The assessment also indicated R2 may be slow to follow directions and staff were directed to wait for the resident to respond, speak slow, take their time, and then take initiative to assist the resident.

Review of recorded video footage of the incident in R2's room showed the AP cleaning/ wiping R2's bottom while the resident was laying on her right side. The resident screamed out, "please help me before I die! I just want to get out of here, she has a horrible temper!" The AP then attempted to forcefully roll R2 from her right side to her back and the resident yelled, "help, she's trying to kill me"! Another staff walked into the room and stated, "Nobody is trying to kill you, what could be so terribly wrong"? R2 responded, "she's beating the tar out of me!" The AP continued to turn the resident from side to side in bed while attempting to get R2 dressed. The AP said in loud voice, "You're making this harder than it's got to be!" The AP pointed her finger in the resident's face and repeatedly taunted the resident stating to R2, "you say somebody's mean, look in the mirror, look in the mirror, look in the mirror, look in the mirror, look in the mirror!" The AP and the other staff assisted the resident to sit up on the edge of the bed and told R2 they were going to get her out of bed. They grabbed the back of R2's pants and under her arms and lifted R2 up to a standing position to transfer R2 to the wheelchair. The wheelchair was unlocked and rolled away from the resident when they attempted to sit the resident down. The staff stepped to the side to grab the wheelchair and the AP was hanging onto the resident by her left arm and the back of her pants as R2 was hanging and unable to bear weight on her legs. The staff grabbed the wheelchair and they both forcefully pulled the resident by the back of the pants into the wheelchair. The resident continued to cry saying, "I'm going home, I can't take this! Why did you treat me so mean?" The AP stated to R2, "I would love for your people to come and get you!" The resident stated in a loud voice, "I don't want you to touch me!" The AP responded to R2, "I don't want to touch you!" The AP continued to adjust R2's position in the wheelchair as R2 became more agitated and screamed, "help, police, police!" The AP and staff boosted R2 in her wheelchair as the resident continued to cry and scream. R2 told the AP, "I don't want this on", and appeared to pull at her necklace. The AP told R2, "you look pretty and clean, and that's what you're wearing". The resident muttered an indeterminate sentence, and the AP loudly said to R2, "when I finish my job, I don't want to be in here!"

A facility incident report indicated the camera footage was reviewed from R2's room. The report indicated the AP was observed telling R2 her family should come and care for her. The AP told R2 the resident was treating the AP badly because of the AP's race. The incident report indicated the staff working with the AP during the incident stated she was upset about how they transferred R2, and she did not like the way the AP was talking to R2. However, the staff stated she was "intimidated" by the AP, so she did not intervene.

When interviewed the AP stated the morning of the incident R2 was having behaviors. The AP stated she was having personal problems and should not have come into work that day. The AP stated R2 did not like her so when the AP entered R2's room the resident told the AP to leave. The AP stated she told R2 she was "mean," because the resident had told the AP she was mean. The AP stated R2 required assistance of two staff and a mechanical standing lift for transfers. However, the AP stated she did not use the mechanical lift because R2's family member told her R2 does not like the lift.

In conclusion, the Minnesota Department of Health determined abuse 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.

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;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;
(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; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, unable due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and ensured all staff were trained on reporting maltreatment.

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

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 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL CARE CENTER	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: /#HL344265383M/ #HL344269275C # HL344266526M/ #HL344262254C On May 16, 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 50 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL344269275C /#HL344265383M, tag identification 0620, 2360, and 3000. The following correction order is issued for #HL344262254C/ # HL344266526M, tag identification 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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of abuse for one of one resident (R1) with records reviewed. 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). The findings include: R1 was admitted to the facility on January 10, 2023, with diagnoses including psychotic dementia and personal history of traumatic brain injury. R1's vulnerability and safety risk assessment dated February 14, 2023, indicated the resident had a history of physical violence including hitting, kicking, pushing, biting, or grabbing. Staff were to redirect the resident and keep the resident away from others when he is agitated.	0 620		

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0 620	Continued From page 2 A facility undated report titled, "Investigation Report Summary", indicated the Clinical Services Director was notified by a staff member on Monday February 13, 2023, she heard another staff member had tied R1's sweatshirt together on Saturday February 11, 2023, "at the hands so that the resident could not get their hands out of their shirt" The report included written statements by facility employees who had been present during the interaction between the staff member, unlicensed personnel (ULP)-C, and R1. A written statement from ULP-F dated February 13, 2023, indicated R1 was having behaviors of yelling, screaming, swearing, and attempting to hit ULP-C. ULP-C stood over R1, holding his arms or hands to stop the resident from trying to hit her. A written statement from ULP-G dated February 13, 2023, indicated she heard crying and screaming and came out of the bathroom and observed R1 pleading for help while ULP-C was grabbing him forcefully by the wrists. R1 looked like he was in pain. R1 attempted to hit ULP-C, but she grabbed him again very forcefully. A written statement from ULP-E dated February 13, 2023, indicated ULP-C was standing over R1 and he was swearing at ULP-C. ULP-C walked away and R1's hands were tied up in his shirt. ULP-E indicated she took the knot out of R1's sweatshirt. When interviewed on on May 16, 2023, RN-B stated the facility completed an internal investigation and felt no abuse occurred so the incident was not reported to MAARC (the state agency).	0 620		

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0 620	Continued From page 3 A undated facility policy titled "Elder Abuse" indicated, all staff and volunteers were mandated reporters. "Reporting of any suspected, alleged, or witnessed abuse or neglect will be completed according to state reporting requirements". No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 620		
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: Based on interview and record review, the facility failed to ensure two of two residents, R1 and R2, were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has	03000		

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03000	Continued From page 4 been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common	03000		

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03000	Continued From page 5 entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of abuse for one of one resident (R1) with records reviewed. 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). The findings include: R1 was admitted to the facility on January 10, 2023, with diagnoses including psychotic dementia and personal history of traumatic brain injury. R1's vulnerability and safety risk assessment dated February 14, 2023, indicated the resident had a history of physical violence including hitting, kicking, pushing, biting, or grabbing. Staff were to redirect the resident and keep the resident away from others when he is agitated.	03000		

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