Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL344267626M
Compliance #: HL344264226C

Date Concluded: March 25, 2024

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

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

Evaluator's Name: James P. Larson, 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 two residents (Resident #3 and Resident #4) when she sprayed water in Resident #3's face in retaliation to the resident being uncooperative, and on another occasion, spit in a glass and offered it to Resident #4 to drink.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. It is unable to be determined if the incidents occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the residents' family. The investigation included review of resident medical records, employee training, facility documentation and policies and procedures. Also, the investigator toured the facility and observed staff to resident interactions.

Resident #3 resided in the memory care unit. Resident #3's diagnoses included traumatic brain injury, arthritis, and glaucoma. The resident's service plan included assistance with medication management, bathing, housekeeping, laundry, meals, and safety checks. The resident's assessment indicated signs of sundowning (behaviors including confusion, anxiety, aggression or ignoring directions, which appear later in the day).

Resident #4 also resided in the memory care unit. Resident #4's diagnoses included traumatic brain injury and dementia. The resident's service plan included assistance with medication management, bathing, housekeeping, laundry, meals, and safety checks.

A facility report indicated an unlicensed staff member/alleged perpetrator (AP) was witnessed spraying Resident #3 in the face during a shower. It was also reported that the AP spit in glass and offered it to Resident #4 to drink.

During an interview, a nurse stated that on the day of the alleged incident, the AP reported she was bit by Resident #3 while providing care and showed the nurse a bite mark on the AP's chest. Later that same day, another staff member reported to the nurse that she witnessed the AP spraying Resident #3 in the face with water during a shower.

During an interview, the witness recalled passing by Resident #3's room and heard Resident #3 yelling, "Stop it!" Upon entering the resident's room, she witnessed the AP repeatedly using the handheld shower head to spray water directly into the face of the resident. The caregiver attempted to stop the AP, but the AP continued to spray water in the resident's face. The caregiver asked the AP to leave, and she assumed care of the resident and completed the shower.

During an interview with a staff member who witnessed the AP drinking from a glass while assisting residents, the staff member recalled telling the AP to stop drinking at the table but did not witness the AP spitting in a cup and offering it to Resident #4.

During an interview with facility administration, they stated internal investigations were completed related to the allegations involving the AP and Resident #3 and Resident #4. Administration indicated the AP denied the allegations; however, following the investigations the AP was terminated.

Resident #3 and Resident #4 were observed at the facility within the locked memory unit and were unable to be interviewed due to cognitive impairment.

During an interview with a family member of Resident #3, they stated the facility informed them of the allegation concerning the bathing incident. The family stated the internal investigation led to the dismissal of the AP and they had no other concerns with the care provided by the facility.

During a conversation with Resident #4's family, they stated they were informed by the facility of the allegation concerning the drinking glass incident. The family stated that they understood it to be an isolated incident and had no concerns with the care provided at the facility.

Attempts to contact the AP were unsuccessful.

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

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.

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;

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

Action taken by facility:
The facility conducted internal investigations into the incidents and the AP was terminated.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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 01/19/2024

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: #HL344266502C/#HL344268886M #HL344265863C/#HL344268525M #HL344264226C/#HL344267626M #HL344265882C/#HL344268487M On January 18 and January 19, 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 41 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL344266502C/#HL344268886M, tag identification 0730. The following correction order is issued/orders are issued for #HL344265863C/#HL344268525M, tag	0 000	The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. 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 SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	

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0 000	Continued From page 1 identification 2310 and 2360.	0 000	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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730		

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0 730	Continued From page 2 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was implemented for one of one resident (R1). The licensee failed to document that safety checks were completed. The resident was found on the floor after an unwitnessed fall and was admitted to a local hospital. 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 had an admission date of June 22, 2023. R1's record was reviewed. R1's diagnoses	0 730		

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0 730	Continued From page 3 included Alzheimer's disease, cognitive communication deficit and major depressive disorder with occasional confusion and some difficulty recalling details. The resident's service plan included assistance with safety checks every two hours. The resident's medical record indicated an entry in the progress notes section that staff had noted an increase in agitation leading toward the hours prior to the unwitnessed fall. R1's record lacked written acknowledgement of completion of every two-hour safety check during the overnight shift from 10:00 p.m. September 28, 2023 until the resident was found in his apartment on the floor at approximately 2:00 a.m. September 29, 2023. During a discussion with a current facility administrator on January 19, 2024, she stated was not aware of the incident and was not able to comment on the events. During interview on January 31, 2024 unlicensed personnel (ULP)-Q stated that staff members were interacting during scheduled safety checks and at times between the checks with the resident attempting to deescalate his behaviors due to the resident's increased agitation. ULP Q stated a team approach was used to determine who was chosen to chart in the resident's chart dependent on assignments that shift and was unable to recall who was responsible to chart on this resident that shift. The licensee-provided policy titled " Care / Service Plan " dated May 20, 2022, indicated service plans were based on outcomes of assessments and individual reviews of resident needs and preferences.	0 730		

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0 730	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards related to supervision and safety for one of one resident (R2). The resident was identified as an elopement risk and eloped from the facility twice over the span of one month. 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:	02320		

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02320	Continued From page 5 R2's diagnoses included dementia, and schizophrenia. R2's signed service agreement dated May 3, 2023, included assistance with medication management, bathing, housekeeping, laundry, meals, and safety checks. This service plan also included a safety check schedule, indicating the staff were to provide every two-hour safety check and additional hourly checks as needed. Review of R2's medical record included a level of care evaluation titled; Preadmission Assessment dated April 28, 2023, which indicated a history of wandering at night. R2's Vulnerability, Safety and Risk Assessment dated May 1, 2023, did not indicate a risk or history of elopements. R2's progress notes included an entry dated August 5, 2023, that indicated R2 was found outside the facility by local law enforcement at 12:25 a.m. and was returned. R2's nursing assessment completed August 5, 2023, indicated the assessment was completed related to a significant change of condition and new indications were noted from previous assessments including the addition of a behavior management entry of "Wanders: Elopement Risk". No additional safety interventions were added following R2's August 5, 2023, elopement from the facility. R2's service plan was not updated and safety checks remained every two hours. An incident report dated August 5, 2023, included in the comments section: building door sensors not activated. Follow up included on the report	02320		

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02320	Continued From page 6 indicated taht maintenance checked building doors and windows to ensure everything was locked and secured. The incident report also included system follow up: monitor the resident for any change in condition, staff training given, MAARC report filed, guardian notified. There was no documentation of what type of training was provided to staff or when the training was provided. There was no evidence of review of staff monitoring or observation of the resident. No additional measures were implemented to prevent future elopements. R2's progress notes included an entry on September 11, 2023, which indicated the hospital contacted the facility around 8:00 p.m. informing them R2 was found at a local business and brought to the hospital by police. He was found to have an abrasion on his right forehead/temple area and a small contusion on his right hand. Service records from September 11, 2023, indicated five safety checks were completed that day, although there is no record of what time they were completed. Progress notes indicated that the last time staff saw R2 was at approximately 6:00 p.m. on September 11, 2023. R2 returned to the facility on September 12, 2023. Upon R2's return to the facility no additional safety interventions were implemented and there was no increase in supervision of R2. R2's service plan was not updated and safety checks remained every two hours. A September 11, 2023, incident report regarding R2's elopement included follow-up interventions of changing door alarm settings, staff were reminded to monitor the resident closely, and to keep the resident in common areas. There was	02320		

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02320	Continued From page 7 no evidence of additional investigation into the incident. There was no review of staff observation or supervision of the resident and no update made to R2's plan of care or service plan to mitigate future incidents. During an interview licensed assisted living director (LALD)-A stated that the resident would often attempt to assist kitchen staff in clearing dishes after a meal was served. An internal investigation was unable to confirm R2's route out of the building, although a kitchen door was confirmed to be propped open that evening. The current LALD was not employed as the LALD at the time of the elopements and had no knowledge of the internal investigations into the elopements. During an interview the registered nurse (RN)-B stated the resident had a shuffling gait. She went on to state that the internal investigation into the incident it was unable to determine which facility door R2 may have left from, although he was often seen in the dining area adjacent to the kitchen after meals often. The licensee-provided policy titled "Incident Reports" dated May 20, 2022, indicated Certain Incident types which represent a real or potential risk of harm or injury to the resident are considered Sentinel Events. Sentinel Events include the following: Resident Elopement. The Policy indicated that incident reports are completed with the shift that the incident occurs and investigated within 48 hours occurence. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02320		

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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 five resident(s) reviewed (R2) was free from maltreatment. Findings include: 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		