Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352301451M
Compliance #: HL352302896C

Date Concluded: October 24, 2022

Name, Address, and County of Licensee Investigated:
Urbana Place Senior Living
5601 94th Ave North
Brooklyn Park, MN 55443
Hennepin County

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

Evaluator's Name:
Lena Gangestad, RN, Special Investigator
Christine Bluhm, 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.

Allegation(s):
The alleged perpetrators (AP) emotionally abused the resident when the resident was found on the floor and the APs did not comfort her but spoke with each and laughed. The APs neglected the resident when they failed to prevent her from crawling across the floor and further injuring herself.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse and neglect were not substantiated. While the APs failed to provide courteous person-centered care when they found the resident on the floor, they did contact the nurse for advice and follow-up for the resident's fall. Although there was a delay due to the nurse's phone was out of battery, the facility staff members, and the licensed practical nurse (LPN) ensured the resident received proper care after.

The investigation included interviews with facility staff members, including the director of nursing, nursing staff, and unlicensed staff. In addition, the investigator contacted family members (FM), hospice nurse (HN), other residents and their family members who resided in the memory care unit. The investigation included review of facility incident reports, medical records of four other residents who had a history of falls, a police report, background study of all APs and policies. The investigation included a review employee files for evidence of required training. The resident's facility record, and the resident's death certification were reviewed. Also, the investigator observed general interactions of staff with residents while on site.

The resident resided in an assisted living memory care unit. The resident's diagnosis included dementia, Parkinsonism, and anxiety disorder. The resident's most recent assessment indicated she required assist of two with mechanical lift for transfers due to increased risk for falls related to back pain and increased confusion. She also required assistance of one person with activities of daily living and medication administration.

Review of the facility investigation notes and video footage, which indicated the first staff member (AP1) entered the resident apartment at 6:11 p.m., put the pillow under the resident's head, and told her she would call for a nurse. AP1 asked the resident if she had pain and she said yes. AP1 left the resident's apartment at 6:13 p.m. to find someone to help. Three staff members entered the apartment together at 6:14 p.m. and called for the nurse again. The second staff member (AP2) called for the nurse at 6:18 p.m., the nurse did not answer. AP2 left the room at 6:19 p.m. to find the nurse. AP1 and the third staff member (AP3) were still in the apartment and told the resident they were not supposed to get her up and they need to wait for the nurse. At 6:21 p.m., the resident crawled to the bathroom while the AP1 and AP3 stood there, watching the resident crawling, and talking to each other. AP2 came back and was unable to find the nurse. AP3 left to find a nurse. The resident started screaming for help. AP1 left the apartment at 6:28 p.m. with a garbage bag after assisting the resident toileting. AP2 wheeled resident out of her apartment at 6:28 p.m. and ran into the LPN in the hallway at 6:29 p.m. and told her what happened.

The resident's medical record indicated the LPN assessed and the resident did not sustain a physical injury from the fall or crawling across the room. The resident's medical record also indicated the facility completed a vulnerability assessment and change of condition assessment on the resident the next day.

During an interview, AP1 stated she was no longer work for the facility and did not remember anything related to resident or the incident.

During an interview, AP2 stated she entered the apartment and saw the resident was on her back with the pillow underneath her. She and other staff members told the resident to stay put and wait for the nurse. AP2 confirmed they did not touch the resident to get her up because the resident complained of chest pain and eventually the resident started crawling to the

bathroom. AP 2 went to find a nurse, so she checked the office, break room and hallways but the nurse was not there. When AP2 came back, the other staff members were in the bathroom helping the resident. AP2 admitted that it was inappropriate to laugh in that situation, but she stated the staff members did not laugh at the resident.

During an interview, AP3 stated the resident fell but she did not know how she fell. AP3 stated she learned about the situation because AP1 told her. When they entered the apartment together, the resident was lying on the floor, and they put the pillow under her head to get her comfortable. AP3 stated they tried to call the nurse, but she did not answer her phone. AP3 confirmed from what she knew, the resident had a surgery a day before and she also complained about pain, so the staff would not want to touch her or get her off the floor. AP3 tried to explain to the resident why she could not get her off the floor and the resident started crawling to the bathroom. AP3 admitted they laughed about the nurse and not about the resident. She said they stood in the room and waited for the nurse but in the meantime, they did not touch the resident and she crawled herself to the bathroom's door. The staff members then decided to help the resident using the bathroom and assisted her to the wheelchair.

During an interview, the LPN stated she was on duty when resident fell. However, her Ascom phone (a phone used for staff members to contact each other) was not working properly, so the staff members were not able to reach her. The staff members got the resident up off the floor without the LPN however she did an assessment as soon as she saw the resident in the hallway. The resident did not have any injury after the fall. However, she was in pain, and the LPN gave her a pain medication. The LPN stated she called the family to notify about the incident.

During an interview, a hospice nurse (HN) stated she came out the facility to provide the end-of-life care. One that day, HN asked the staff for their assistance to use mechanical lift to get the resident out of bed so she could replace the air mattress for her. The staff refused to help. They told her they were too busy, so HN reported the staff to the facility's nurse. When the staff found out the HN reported them, they retaliated against her by yelling at her in common area and refusing to answer her call lights for the rest of the evening. The HN did not know the name of the staff working that night but confirmed it happened on Saturday.

During an interview, a family member stated her daughter got on the camera and saw the resident crawling on the floor. Furthermore, the daughter stated three staff in the room was pointing and laughing at the resident. The resident's daughter and her husband drove to the facility and called the police. She talked to the administrator and expressed concern about what occurred.

During an interview, the director of nursing (DON) stated the facility got a phone call from the resident's family member who was concerned the resident fell on the floor and when staff members responded they did not help her but rather laughed at her mother while she was crawling and not helping her. The DON stated she immediately assigned different caregivers to the resident while the facility conducted an investigation. DON stated she could not dismiss the

staff because it was 7 p.m., and they could not find the staffs to replace them. The management team looked at the hallway's camera and heard the resident calling out for her daughter. One of the staff members walked in and gave the resident pillow, then went to look for help. The DON stated the staff members were trained to call the nurse first to make sure the resident had no injury before they could move the resident. The DON acknowledged while the staff members were waiting, they were talking among themselves and were not attending to the resident as best as they could. The incident started at around 6:10 p.m., and they found a nurse around 6:30 p.m. The DON stated her expectation for staff in that situation was to call for help, then comfort and stay with the resident.

The investigator reviewed the pertinent employee files. The APs' employee records indicated the facility terminated employment of two of the AP's due to progressive disciplinary action. The facility provided the other AP with disciplinary action and re-education although her employment was terminated for unrelated reasons later. A review of the nurse's employee file indicated she received re-education on use of the Ascom phones.

In conclusion, the Minnesota Department of Health determined emotional abuse and neglect were 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.

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.

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: No, the resident was deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility conducted an internal investigation, which included placing the APs on suspension pending an investigation. The facility conducted facility-wide re-education regarding falls and guidelines to call the on-call nurse if the nurse on duty did not responds within five minutes. The same education included information on ensuring residents were comfortable and safe while awaiting a return call from a nurse. The facility completed a facility-wide check of all Ascom phone batteries to ensure proper functioning.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	C 09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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 ******ATTENTION****** 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: #HL352302902C/#HL352301453M #HL352302896C/#HL352301451M On September 13, 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 89 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL352302902C/#HL352301453M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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 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. 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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02360	Continued From page 1	02360		
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 observations, interviews, and document review, the facility failed to ensure one of three residents reviewed (R1) was free from maltreatment. R1 was financial exploited. Findings include: The Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report (report sent separately) for details.	