Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352303661M
Compliance #: HL352304066C

Date Concluded: August 20, 2024

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

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

Evaluator's Name: Lissa Lin, 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 AP abused the resident when she repeatedly yelled at the resident to stand up from her wheelchair, and repeatedly tipped the resident's wheelchair forward to force the resident to stand even though she did not want to stand and was distressed. The AP also used threatening and aggressive language and gestures during toileting and transferring.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP abused the resident when she ignored her training and tried forcing the resident to stand up from her wheelchair to transfer. The AP repeatedly lifted the back wheels of the resident's wheelchair off the floor and tipped it forward to force the resident to stand even though she did not want to. The AP used aggressive and threatening language at the resident during toileting and transferring. The resident was visibly distressed; she yelled "Ow" multiple times and pushed the AP's hands away from her.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident records, the facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures and video of the incident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included vascular dementia, age-related osteoporosis and chronic heart failure. The resident's service plan included assistance with toileting and incontinence cares and transfer assistance with one staff member. Staff were to provide assistance to monitor behaviors in a supportive environment.

The resident's admission assessment indicated she required mobility and walking assistance. She could make her needs known and was able to understand others. The resident was sometimes resistive to help from others or "hard to handle." Her assessment indicated her dementia diagnosis included forgetfulness, confusion, impaired decision making, verbal and physical behavior issues. Non-pharmacological interventions were sometimes helpful.

Review of the resident's records indicated she could be verbally and physically aggressive with staff and resistive to cares due to cognition changes. Interventions included maintaining routines, provide consistent caregivers, speak slowly, use facial expressions and gestures to enhance communication, give the resident ample time to communicate and verify understanding, observe her facial expressions, behavior symptoms and vocalization for unmet needs.

The investigator reviewed two segments of the resident's family provided, in-room camera footage; both segments were about two minutes long. The segments lacked date and time stamps.

The first segment showed the AP and resident in the resident's bathroom. The AP lifted and tipped the resident's wheelchair forward as the resident grasped a grab bar next to the toilet. The AP yelled "Stand up!" and shoved the wheelchair forward slightly. She told the resident to stand up repeatedly in a loud, aggressive tone. The resident clung to the grab bar but remained seated in the wheelchair. The AP moved to one side of the wheelchair. She tipped the wheelchair up higher and pulled it away from the resident, who remained in a seated position and held onto the grab bar. The AP said something unintelligible to the resident, and then told her again to stand up. The AP pushed the wheelchair farther away with one foot and pulled the resident up to a standing position. The resident screamed "Ow, ow, ow". The AP aggressively pulled down the resident's pants and underwear and seated her onto the toilet. The resident screamed "Ow". The AP placed a new brief on the resident, then stood over her and asked if she had "peed." When the resident said she did not know, the AP told the resident to pee a fee times, "so we can go."

The second segment showed the resident seated in her wheelchair facing the side of her bed with her back to the camera. The AP walked up behind the resident's wheelchair and said in a loud aggressive tone "Ok stand up let's go… stand up, stand up. You're not gonna do this thing, stand up." The AP lifted the back wheels up, tipped the wheelchair forward and shook the wheelchair. The resident grasped the edge of the mattress but did not stand. The AP leaned forward toward the resident who yelled "Ow, will you quit pinching me!" The AP said she did not pinch her and then told the resident "Don't bite me, I will bite you if you bite me."
The resident screamed "Ow…so you'd bite me, you ass!" The AP moved to one side of the wheelchair, stood over the resident and asked why she lied when there was a camera back there and her daughter watched everything? She told the resident it was not ok to lie. The resident told the AP she was a liar and struck out at the AP's hands. The AP bent down closer to the resident and asked what did she lie about? The AP asked that question several times. The resident yelled "Everything!" She remained seated in her wheelchair. The AP left the room for about 40 seconds. The AP returned to the room and told the resident she (the AP) needed to find help to get the resident into bed.

Review of the internal investigation records included an untitled AP incident summary. The summary indicated the manager called the AP and asked her to review how her cares went the previous evening in memory care. The AP said she cared for the resident (identified by her group number and apartment number). The resident was difficult to care for, she refused her medications and toileting. The AP needed another staff person to help get the resident to bed. The resident took an hour to complete cares because she resisted all the time. The AP said the resident swore at her and she told the resident not to swear and let her help. The AP stated she told the resident it was okay if she could not stand up. She did not recall yelling at the resident.

Facility management conducted employee and memory care resident interviews. None of the employees had concerns about or witnessed other staff members abusing the memory care residents. Memory care residents interviewed felt safe and said staff treated them well. The nurse also conducted skin audits of memory care residents. There were no injuries of unknown origin.

A notice of discipline gave the AP a final written warning "Employee was observed via camera on evening of [date] attempting to unsafely transfer a resident with dementia to the bed and bathroom. Employee also failed to use therapeutic communication matching the cognitive status of the resident during the interaction." Corrective action included two days of classroom retraining on dementia cares, completing computer modules on dementia's challenging behaviors and handling aggression, retraining with a lead care giver, and after 30 days conduct a skills competency test with the nurse. The AP would no longer work in memory care.

Review of the AP's personnel file indicated she completed and passed new hire trainings on reporting maltreatment of vulnerable adults, the aging process, caring for those with dementia, communication (preserving dignity and respect) and transfer and ambulation.

During an interview, the AP said the resident was difficult to be with and she often refused cares. The AP said she had training on how to work with memory care residents, including reapproaching residents who declined cares. The AP said it was important to know what to say to residents so they would agree to allow cares. She said the resident was especially difficult when she needed to go to bathroom. The AP said the resident had to hang onto the bathroom grab bar to stand. If the resident was tired, then standing was hard for her, so the AP lifted her (wheel)chair up a little bit to help her stand. The AP said lifting the wheelchair up to make the resident stand was not part of her training. She did not consider pulling the wheelchair away from the resident a safety issue. The AP said she spoke loudly to the resident because someone told her the resident could not hear and she always screamed; she screamed even when staff did not touch her. The AP said when the resident screamed, she asked if she was ok. The AP said she did not shake the wheelchair when she tried transferring the resident to her bed. The AP said lifting the wheelchair up was a mistake because she was not trained to do that, but she did not abuse or maltreat the resident. The AP said management suspended her from work during the internal investigation and she took re training courses before she returned to work. She left her job a few weeks later due to knee issues.

During an interview, the nurse said she and the manager watched the camera segments and they felt the AP treated the resident roughly, especially in the bathroom.

During an interview, the manager said the resident was intermittent with her cognition and staff determined using one aide to regularly care for her at first was better for the resident's mood. The manager said the resident did not like people coming up behind her, it scared her. The manager said she and the nurse watched the video segments and it was clear the resident was visibly upset and uncomfortable with the AP during cares because she yelled "Ow" several times when the AP made her stand in the bathroom. The manager said the AP also rushed the resident during toileting and was "curt" (short) with her when talking to her. The manager said when the AP lifted the back wheels of the wheelchair up it looked like she wanted to "dump" the resident into her bed. Tilting the wheelchair and forcing a resident to stand was not part of staff training.

The resident's family member said the resident moved to the facility's memory care unit so she could get better 24-hour cares. The family member said the resident sometimes soiled herself instead of letting some caregivers take her to the bathroom, because she did not trust them. The resident did not tell the family member who those staff members were. The family member said the resident was not always an easy person to take care of, but she responded well to staff who talked with her and explained things as they did them. She said it was clear on the camera segments that the resident grew increasingly agitated when the AP "barked" commands at her, tipped her out of the wheelchair in the bathroom and again at the bedside. She said the resident crouched in a "water-ski position" at the bathroom grab bar and that did not look safe. The family member said the AP struggled with caring for the resident in the past. The family member said management did not update her on any actions against the AP, she just did not

see the AP working in memory care anymore. She was unhappy with the care and communication of the facility. She transferred the resident to a new provider.

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:
(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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, she transferred to a new provider.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended AP and conducted internal investigation. The facility’s actions included requiring classroom re-training for dementia cares before returning to work, the AP required

supervision for 30 days and required to pass a skills competency and the facility did not schedule the AP to work in the memory care unit.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

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 07/31/2024

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 ******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: HL352304066C/HL352303661M On July 31, 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 88 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL352304066C/HL352303661M, tag identification 2360.	0 000	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. 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 reviewed (R1) was free from maltreatment. Findings include: 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.	02360	No plan of correction is required.	