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State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354473089M
Compliance #: HL354475094C

Date Concluded: May 8, 2023

Name, Address, and County of Licensee Investigated:
Parks Place Memory Care
18040 Medina Road
Plymouth MN, 55446
Hennepin County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

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 perpetrators (AP #1 and AP #2) abused a resident when they "threw" him into bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP's followed the plan of care for the resident. There was not evidence of the AP's roughing transferring the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, employee files, internal investigations, incident reports, and facility policies. The investigator toured the facility and observed interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included

Alzheimer disease, dementia, and severe spinal stenosis. The resident's service plan included assistance with dressing, toileting, bathing, hygiene, medications, meals, laundry, and housekeeping. The resident's nursing assessment indicated the resident was resistive and required two unlicensed personnel (ULP) to provide cares.

A facility incident report indicated an ULP saw AP #1 and AP #2 "throwing" the resident to the bed. The report indicated the ULP told them to stop so she could dress him.

During an interview, ULP said the resident required two staff to help him stand because he could become stiff and fight. The ULP said she was behind AP # 1 and AP #2 as they walked the resident to his room. She asked AP # 1 and AP #2 to leave him standing so she could dress him. The ULP said AP #1 and AP #2 did not respond to her and "pushed" the resident onto the bed. The resident then sat on the bed, then laid down. The caregiver said she had to get another ULP to help her get him up. The ULP said AP #1 and AP # 2 were not "fair" to her.

During an interview, AP #1 said she worked the night shift. AP # 1 said the resident required two staff to provide care for him because he was aggressive. The resident was sitting outside his room during the night, so she got help from AP #2 to put him in his bed. AP #1 said they put him in his bed so the morning caregiver could get him dressed. AP #1 stated she did not push the resident.

During an interview, AP #2 said they were not supposed to leave the resident outside of his room at the end of their shift. AP #2 said leadership expected the night shift ULPs to get the resident to his room, so the day shift ULPs could dress him. AP #2 said her, and AP #1 walked the resident to his room and put him in bed. After they put the resident in bed, the day shift ULP asked them to get him up so she could dress him. AP #2 said she told the ULP she had to leave and asked her to get another ULP to help her get him up. AP #2 stated she did not push the resident.

During an interview, a nurse said the resident was resistive with any type of cares and he required assistance from two staff members.

In conclusion, the Minnesota Department of Health determined abuse was 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" means:
(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.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, did not return calls.
Alleged Perpetrator interviewed: Yes, both AP #1 and AP #2.

Action taken by facility:
The facility provided education to staff.

Action taken by the Minnesota Department of Health:
No further action required.

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
	35447	A. BUILDING: _____ B. WING _____	C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKS' PLACE	18040 MEDINA ROAD PLYMOUTH, MN 55446

(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 On April 24, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL354475162C/#HL354473108M and HL354475094C/HL354473089M . No correction orders are issued.	0 000		