Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354473108M
Compliance #: HL354475162C

Date Concluded: May 4, 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 perpetrator (AP) abused a resident when she pushed and pulled the resident which resulted in the resident receiving a bruise on her wrist.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the resident had bruising on her wrist, facility documentation indicated bruising was present one week prior to the allegation. In addition, after the AP no longer worked at the facility, the resident continued to sustain bruises to her wrist.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. 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 dementia with behavior disturbances, chronic pain syndrome, anxiety, and depression. The resident's service plan included assistance with dressing, toileting, showering, meals, laundry, medications, and behavior management. The resident's nursing assessment indicated the resident was confused and difficult to understand. The resident required assistance with decision making. The resident walked with a walker, but needed direction from staff.

A facility incident report indicated the resident said the AP yelled and threw clothes at her while she was helping her get dressed. The report indicated the resident said the AP pulled on her arms. The report indicated the resident had two bruises on her left outer wrist. The resident denied pain and required no further medical attention. The report indicated the facility removed the AP from the schedule and proceeded to termination.

During an interview, the AP said she worked the night shift hours and was responsible for getting the resident up from bed and dressed for the day. The AP stated she did not hurt the resident and did not push or pull the resident's wrist. The AP said the resident was confused, but would participate in her morning cares. The AP said she noticed a bruise on the resident's hand prior to the allegation and reported it to the nurse at a morning meeting. The AP said the facility nurse told her she already knew about the bruise.

The resident's progress notes indicated approximately one week prior to the incident staff noticed two bruises on the resident's left wrist. The bruises were small, and the resident was not aware of them. The resident denied pain and was unsure how she received the bruises. The progress notes indicated the resident slept with her hands in a praying position, close to the side rail, and transferred in and out of bed continuously, independently.

The resident's progress notes lacked any documentation for a twelve-day period. During those twelve days, the incident with the AP occurred. Nine days after the AP no longer worked at the facility, progress notes indicated staff requested an X-Ray of the resident's left hand because her index finger was swollen and painful. The X-Ray result indicated there was no fracture or injury to the resident. Ten days later, the resident's progress notes indicated staff observed bruising to the resident's left wrist. The notes indicated the resident transferred in and out of bed independently with the side rail.

The resident's electronic medication administration record (eMAR) indicated the resident received anti-psychotic medication every day. In addition, the resident received additional dosages of the medication for increased anxiety, prior to the incident.

During an interview, a family member said the resident had memory loss and the disease only gets worse. The family member said the resident was not steady on her feet and required a walker to assist her. The resident could be resistive with care; she was paranoid and talked about someone trying to kill her. The family member said the resident appeared clean and staff

provide adequate care. The family member said the physician adjusted the resident's medications and she appeared to be calmer and less agitated.

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 due to memory loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility coordinated care with medical providers.

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
	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		