Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354472789M
Compliance #: HL354474787C

Date Concluded: October 31, 2022

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

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

Evaluator's Name:
Katie Germann, RN, Special Investigator
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The facility staff abused a resident when the resident was restrained with pillowcases during cares, causing bruising to the resident's arms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined the allegation of abuse was inconclusive. Staff reported to administration the resident was restrained with pillowcases placed over his hands during cares. However, no staff witnessed this occurring, there was no evidence the resident was restrained, and no evidence of harm to the resident.

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 medical records, physicians' notes, facility policies and

procedures manual, employee files, and training records. Also, the investigators observed staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance, Alzheimer's disease, and purpura. The resident's service plan included assistance with activities of daily living, shower assistance, medication administration, housekeeping, laundry, and meals. The resident's assessment indicated the resident has cognitive impairment and had a history of agitation and anxiety when staff attempt to help with cares.

Staff reported the resident had bruising on both of his arms. During the facility investigation of the bruising, staff reported to administration that pillowcases had been placed over the resident's hands during cares to prevent the resident from scratching staff while providing daily cares.

During an interview, an administrator stated they were informed of bruising on the resident's arms by a staff member who provided cares for the resident that day. The administrator saw the resident's arms and noted redness. The administrator stated the redness looked like bruising. The following day, the administrator and a nurse observed the resident's arms and there were no signs of the redness that was observed by the administrator the previous day. The administrator stated they heard of pillowcases being used on the resident's hands during cares but did not know who put the pillowcases on the resident's hands, or when that might have happened. The administrator described the reports as rumors.

When interviewed, a nurse reported upon hearing of the bruising she assessed the resident's arms. The nurse stated the redness did not appear to be bruising, but more like a rash. The nurse stated a caregiver reported they overheard other caregivers talking about putting pillowcases over the resident's hands to prevent the resident scratching staff during cares. The caregiver was not able to say who they heard that from or which caregivers were putting pillowcases on the resident's hands. The nurse reported due to this information she provided updated training to all staff regarding restraints and appropriate interventions as alternatives to using restraints.

Review of physician notes indicated the redness on the resident's forearms and back of his hands was purpura, a condition in which small blood vessels burst causing red spotting on the skin.

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; Stop here if it is not a restraints issue or sexual abuse.
(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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

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

Action taken by facility:
The facility provided training to staff regarding restraints and using appropriate alternatives to restraints during resident cares.

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 10/11/2022

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 Initial comments On October 11, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL354474787C/#HL354472789M. No correction orders are issued.	0 000		