Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36021009M
Compliance #: HL36021010C

Date Concluded: October 3, 2022

Name, Address, and County of Facility Investigated:
The Preserves of Roseville
2600 Dale Street North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Lori Pokela R.N.
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.

Allegation(s):
The resident was neglected when the AP placed the resident's call light pendent out of reach after the resident had turned on the call light pendent multiple times.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was a lack of evidence to support that the resident's call light pendent was taken away from the resident. The resident's baseline behavior consisted of the resident turning on his call light pendent numerous times. One document indicated unlicensed personnel heard the resident's call light pendent was taken away because the resident used it too much, but the document lacked a date, time and who had taken the call light pendent away.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the resident's medical records were reviewed. Facility documents including internal investigation reports, pertinent policies, personnel files, and training records were reviewed.

The resident's diagnoses included: atherosclerotic heart disease, atrial fibrillation, and chronic kidney disease. The resident had been on hospice at the time of the incident.

A review of a facility incident report questionnaire, undated indicated in two areas that the resident's call light pendent had been out of reach, however, the questionnaire did not have a date or time this had occurred, nor did it indicate which staff was responsible for the call light pendent being out of reach. This same questionnaire indicated a staff to have heard the resident presses his call light pendent too much and one question indicated "When were you told?" and the AP's name was handwritten next to this question.

The resident's medical records indicated the resident to need encouragement to use the call light pendent as the resident had a history of self-transferring that had resulted in falls. These same medical records indicated the resident had moderate disorientation, difficulty retaining/recalling information and staff to monitor behaviors every shift.

The AP's training and competency records, indicated the AP to have completed competency in Bill of Rights, Alzheimer's Disease and Related Disorders: Behavior Management and a facility Code of Conduct form upon hire.

During an interview, nursing management staff stated during another facility investigation, one staff member reported to her that the AP will take the call light pendants away from residents. This same nursing management staff stated the AP would visit with the resident frequently, there were no complaints of this from the resident or the resident's roommate, the AP was mellow, redirectable, polite and never lost his temper. This nursing management staff stated the resident turned-on the call light pendent frequently as this was his baseline due to anxiety-related issues.

During an interview, the resident's family member stated she would not put it past the resident to use the call light pendent often as he may have felt lonely, especially after the pandemic. This same family member stated the resident feel panicked when by himself and the facility did attempt to place the resident at a dining room table with another resident often for company. The family member stated the resident was moved to another facility hopeful that the resident did not feel as isolated.

During an interview, the AP stated he would never take a resident's call pendent away for any reason. The AP stated he thought he had a good relationship with all of the residents at the facility.

In conclusion, it was inconclusive whether neglect occurred.

“Inconclusive” means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

"Neglect" means:
(a) 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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No due to impair cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident. The AP is no longer employed at the facility.

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
	36021	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(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 June 23, 2022, the Minnesota Department of Health initiated an investigation of complaints: #HL36021008C/#HL36021007M #HL36021010C/#HL36021009M #HL36021013C/#HL36021012M No correction orders are issued.	0 000		