*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL36021012M
**Compliance #:** HL36021013C

**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):**
It is alleged neglect occurred when the AP [unknown] yelled at the resident while cleansing the resident's perineal area with alcohol wipes while the resident was screaming out.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was inconclusive. There was a lack of evidence to support the resident was yelled at by the AP while the AP was cleansing the resident's perineal with an alcohol wipe. A recorded video of the incident; however, this video did not have a clear visual of which wipes were used on the resident or who the AP was. A screen shot of a recorded video indicated alcohol wipes were located in the resident's room near the area where incontinent products were stored, but the screenshot did not have a clear visual as to whether the wipes were open and if the wipes had been used to cleanse the resident's perineal area.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator interviewed the resident's hospice nursing staff. The resident's medical record was reviewed. A screen shot of the video recording taken at the time of the incident was reviewed. Photos of the perineal wipes and the alcohol wipes were reviewed. Pertinent facility policies and procedures were reviewed.

The resident's diagnoses included: chronic leukemia ( a cancer of the blood cells that can lower a resident's immunity and cause extreme fatigue) and wound on left buttock area. The resident was receiving hospice services when the incident occurred.

The resident's medical records indicated the resident to have received daily medications for sleeping, cognition deficits and anxiety. In addition to the daily medications, the resident was being administered as needed medication for anxiety at the time of the incident.

The resident's facility service delivery records indicated the resident had used a mechanical lift and assistance of two staff on the date of the incident. This same document indicated eight safety checks were completed with the resident per shift.

The resident's hospice records indicated the resident to need staff reassurance when the resident yells out: "help, help". The hospice records also indicate the resident had a chronic skin condition that caused dry peeling. The resident was to be taken to the bathroom using the mechanical lift and two staff a minimum of six times per day.

The resident's hospice medical records indicated the resident received wound care for an open area on the resident's left buttock, a wound the resident had upon admission to the hospice program [prior to the incident]. This document also indicated a goal to decrease the resident's yelling out and anxious-type behaviors.

The resident's hospice progress notes the date after the incident, signed by hospice unlicensed personnel, indicated the resident had a bath and perineal care was completed without any new concerns.

The resident's hospice physician order form, dated two days after the incident, indicated the hospice licensed nursing staff discontinued wound care to the resident's stage two (open area), left buttock wound, then obtained an order for the resident to receive a zinc-barrier ointment to the open area on resident's left buttock, three times per day and with every incontinent brief change.

The facility had a policy dated August 1, 2021, that indicated staff are to clean equipment such as mechanical lifts to be cleansed routinely, and when appropriate disinfected before and after each use.

A screen shot of a video recording when the hospice aide was in the resident's room. This screen shot dated the next day after the incident, indicated the alcohol wipes were in the same location as the resident's perineal cleansing supplies. The screen shot also indicated there was no clear visual of the wipes being used on the resident, as the wipes were on the bed during the perineal care. There was also no visual of a specific facility staff using the wipes.

During an interview, a hospice unlicensed personnel stated the day after the incident, she had brought a box of alcohol wipes to the nurse that were found on the end of the resident's bed with all the other incontinent supplies. The hospice unlicensed personnel did not see anyone using the alcohol wipes on the resident and the resident had been up in his chair so she could not observe his perineal area.

During an interview dated, unlicensed personnel stated she had observed alcohol wipes in the resident's perineal care items area of his room. The perineal care items were supplied by hospice. The unlicensed personnel had not seen the alcohol wipes used on the resident. The unlicensed personnel had also stated the alcohol wipes were in a similar package as the perineal wipes, are used on the mechanical lift equipment for cleaning, but usually would have been kept in the resident's bathroom.

During an interview dated, an administrative nurse, stated the resident was not able to communicate effectively at the time of the incident. After the incident facility nursing staff checked the resident's room for alcohol wipes and a package was found by the resident's television, away from the perineal care supplies and were unopened. When the administrative nurse viewed the video of the incident, she had stated that the wipes could not be seen clearly on the recording.

An interview, nursing management staff stated the resident's hospice unlicensed personnel approached her with an unopened pack of alcohol wipes that she had found in the resident's room. This same nursing management staff stated she had viewed a video recording of the incident, but it was difficult to visualize which wipes were being used on the resident. The resident's yelling out was a base-line behavior according to the nursing management staff and he would yell "help me" even if staff would be sitting right next to him. Following the incident, the nursing management staff was unable to locate any more alcohol wipes in the resident's room and stated other management staff had removed the alcohol wipes from all the facility resident's rooms. This nursing management staff had stated the alcohol wipes were used for sanitizing equipment like mechanical lifts, such as the resident had at the time of the incident.

During an interview, hospice licensed nursing staff, after viewing the video recording himself, it was difficult to visualize which wipes were being used on the resident during the incident and the wipes package appeared to be "tattered". The hospice licensed nurse also stated it appeared that staff were attentive as they should have been during the incident and the resident's calling out for help was a baseline behavior. The next morning, a hospice unlicensed personnel, had reported finding a package of alcohol wipes next to the resident's incontinent

supplies. This same hospice unlicensed personnel did not report the resident's perineal are to be reddened. The hospice licensed nurse stated he observed the resident's perineal area two days after the incident and a stage two open area that was diagnosed prior to the incident, had improved. The hospice licensed nurse was able to discontinue the wound treatment and obtain an order for staff to apply a zinc barrier cream to the wound area instead.

During an interview, the resident's family member stated she observed, via a video camera placed in the resident's room, the resident yelling "ow" and appeared in pain as the AP was performing perineal care. This family member stated the resident usually yelled out "help" not "ow". The family member stated observing alcohol wipes being used on the resident's perineal area.

In conclusion, it was inconclusive whether neglect occurred.

**Action taken by facility:**
No action taken.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"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, deceased.
**Family/Responsible Party interviewed:** Yes.
**Alleged Perpetrator interviewed:** No, the AP was unknown.

**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<br><br>Initial comments<br>On June 23, 2022, the Minnesota Department of Health initiated an investigation of complaints:<br><br>#HL36021008C/#HL36021007M<br>#HL36021010C/#HL36021009M<br>#HL36021013C/#HL36021012M<br><br>No correction orders are issued. | 0 000 | | |