Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394257586M
Compliance #: HL394253049C

Date Concluded: February 14, 2025

Name, Address, and County of Licensee Investigated:
Hayden Grove of St Anthony
2601 NE Stinson Parkway
St Anthony MN 55418
Hennepin County

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

Evaluator's Name: Maggie Regnier
Special Investigator

Finding: Substantiated, facility responsibility

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 facility abused the resident when an unlicensed care giver placed a wheelchair and recliner against the side of the resident's bed, and pillows under the residents' sheets, confining him to bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. The unlicensed caregiver did place the wheelchair and recliner against the bed, and pillows under the residents' sheets, which confined the resident to bed. Additionally, several other unlicensed caregivers entered the room, observed this confinement, and did not remove nor report this to the facility nurse.

While it was true one unlicensed caregiver initiated the resident's confinement by placing physical barriers next to his bed, multiple of the facility's unlicensed caregivers observed this in

place but took no action to address it until after it was observed by one of the resident's visitors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff and family members. The investigation included review of the resident records, facility internal investigation, facility incident reports, video files, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, residents and visitors.

The resident resided lived in a memory care unit. The resident's diagnoses included Alzheimer's dementia, insomnia, and anxiety. The resident's service plan included assistance with grooming and dressing, ambulation and transferring, medication management and cueing for eating. The resident's assessment indicated the resident had a history of falls and required a fall mat at his bedside. The resident did not use a call pendent but did yell out at times if he required assistance.

An internal facility investigation indicated it became known to nursing and management that a recliner and wheelchair had been positioned at the side of the resident's bed as well as pillows under the sheets to confining the resident to bed.

A video showed an unlicensed care giver lifting the residents' legs back into bed, then positioning a chair and wheelchair at the side of the resident's bed on an evening shift. It is unclear in the video when the pillow was placed under the resident's blanket to also confine the resident to his bed. Video from the resident's room indicated multiple caregivers entered the resident's room however the furniture was left in place surrounding the resident's bed.

A photo image, created the following morning, showed the following physical barriers around the resident's bed.

- The right side of the bed was oriented against a wall
- The left side of the bed had a wheelchair, and a recliner chair pushed up to the mattress
- The left side of the bed had an object, perhaps a pillow, stuffed under the sheet of the bed creating a raised edge
- The head of the bed was partially obstructed by a partition
- The foot of the bed was partially obstructed by a small piece of furniture

A review of the resident's medical record did not identify documentation of a nurse assessment for the use of a physical device to confine the resident to bed, articulation of the reasons for the use of the physical device, nor the risks or benefits of using the device. The same review identified no documentation for the use of physical devices confining the resident to bed. The same review found this same topic was not included in the care plan nor the service plan. The same review found no communication nor an order from the resident's medical provider regarding the use of a device which may have the effect of a restraint.

During an interview, the unlicensed caregiver stated she had never placed any chairs like that before but did so that evening to prevent the resident from falling out of bed. The unlicensed caregiver stated her intent was to prevent harm for the resident, not cause harm. The unlicensed caregiver also stated she had no idea the placing the chairs at the side of the bed may be considered a restraint. The unlicensed caregiver also stated other staff members were aware of the chairs but did not say anything.

During an interview, a manager stated the unlicensed staff reported she did not know placing the chairs at the bedside was considered a restraint. The manager stated the facility provided education to the caregiver regarding restraints to reduce the risk of recurrence.

During an interview, nursing stated that multiple employees over several shifts were aware of the chairs at the bedside but did not move them or report that. Nursing also stated that once she was aware of the incident, the resident was assessed, and no adverse outcomes were noted.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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.

Mitigating Factors 626.557, subdivision 9c

(f) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:
(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
(3) whether the facility or individual followed professional standards in exercising professional judgment.
Vulnerable Adult interviewed: No, due to impaired cognition
Family/Responsible Party interviewed: Yes.
Action taken by facility: The facility reported the incident and re-educated the staff about physical devices which may have the effect of a restraint.

Action taken by the Minnesota Department of Health: The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Anthony Police Department
St. Anthony City Attorney’s Office
Hennepin County Attorney’s Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39425	A. BUILDING: _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE OF ST ANTHONY	2601 STINSON PARKWAY ST ANTHONY, MN 55418

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL394253049C/#HL394257586M On January 15, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 44 residents receiving services under the provider's Basic/Comprehensive Home Care Assisted Living/Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL394253049C/#HL394257586M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for 2360 as its purpose is to doucment maltreatment occurred. Please see the maltreatment report for details.	02360		