Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL402871240M
Compliance #: HL402871800C

Date Concluded: March 24, 2025

Name, Address, and County of Licensee Investigated:
Shekky Care Services Professional Corporation
1160 Chicago Avenue
Saint Paul Park, Minnesota 55071
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Inconclusive

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 neglected resident 1 and resident 2 when resident 2 threatened to hurt resident 1.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the AP failed to intervene, the altercation did not escalate to physical harm after resident 2 made threats to cause substantial harm to resident 1. Additionally, resident 2's record indicated he had verbal aggression towards other but lacked a history of physical violence towards other residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, and the resident 1's and resident 2's case managers. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures.

Resident 1 and resident 2 resided in an assisted living facility.

Resident 1's diagnoses included anxiety. Resident 1's service plan included assistance with monitoring her for signs of heightened anxiety and assuring safety. Resident 1's individualized abuse prevention plan (IAPP) indicated staff were familiar with resident 1's vulnerabilities and needs. The IAPP indicated resident 1 would remain safe during her stay at the community.

Resident 2's diagnoses included a mental health diagnosis. Resident 2's service plan included assistance with monitoring him for signs of heightened anxiety and assuring safety. Resident 2's IAPP indicated the facility had not been aware of the resident being physically aggressive towards others.

An incident report indicated resident 2 had been verbally threatening to physically hurt another resident. Resident 2 called 911 and was arrested due to being an imminent risk and threatening assaultive behavior. The incident report included a letter written by the facility nurse. The letter indicated resident 2 threatened to physically harm resident 1, approaching her closely and continuing to display anger and irritability. Resident 1 responded by saying she would defend herself if resident 2 did not back off. Resident 2 continued the threatening behavior and called 911.

A law enforcement report indicated law enforcement arrived at the facility for reports of a verbal dispute. Resident 2 reported resident 1 threatened to use pepper spray against him. Resident 2 aggressively confronted resident 1 who had been sitting on a couch, gesturing toward resident 1 while yelling and using profanity. Resident 1 warned resident 2 if he did not move away, she would pepper spray him. Resident 2 told resident 1 he would break her in half before she could spray him. The AP corroborated the incident. Facility management informed law enforcement resident 2 had exhibited verbally aggressive behavior towards other residents and pushed a male resident at one time. Law enforcement determined resident 2 to be the aggressor and took him into custody. The report indicated law enforcement had been at the facility within 30 minutes prior to this. During the first visit, resident 1 informed them due to resident 2's outbursts, she carried pepper spray.

During an interview, the nurse stated resident 2 had anger issues and could be triggered easily. After the incident, she completed education with staff regarding how to redirect residents during verbal altercations, and how to deescalate situations.

During an interview, resident 1 stated resident 2 initially called 911 on a different resident. Resident 1 told law enforcement resident 2 had been the problem, not the other resident. Resident 2 came up to her and told her to shut her mouth. Law enforcement told him to stop. Resident 2 left the room. Resident 1 and the AP went and sat down, and law enforcement left the facility. Resident 2 came into the living room and stated he did not care what law enforcement said, he would snap her in half before she could spray him with pepper spray.

Resident 2 called 911 and told them she threatened him with pepper spray. Resident 1 stated the AP just sat there and said nothing.

During an interview, resident 2 stated he originally called law enforcement in the morning due to a disturbance caused by another resident. While speaking with law enforcement, resident 1 burst into their conversation and told law enforcement he was the problem. Resident 2 used expletive language and told resident 1 to be quiet. Law enforcement yelled at resident 2, telling him he could not talk to resident 1 in such a way. After speaking with the other resident, law enforcement left the facility. A few hours later, resident 1 approached resident 2 and started yelling at him. A loud, verbal confrontation ensued. Resident 1 stated she would put him down hard and reached for her coat to get her pepper spray. Resident 2 told resident 1 he would snap her like a twig if she took out the pepper spray. Resident 1 went into the living room while resident 2 exited the facility and called 911. The AP had been there during the whole interaction and did nothing. Resident 2 described the AP as incapable of providing services due to health issues. Resident 2 described the AP doing nothing as careless, negligent, a lack of supervision, and a lack of protection from an attempted assault on him. The AP also did not interact when law enforcement came to the facility the second time. He continued to sit in a chair and did nothing.

During an interview, the AP stated during the altercation, he instructed resident 1 to go downstairs and take a nap, and he told resident 2 to take his medication.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: Resident 1: No, resident 1 declined to interview. Resident 2: Yes.
Family/Responsible Party interviewed: Resident 1: No. No family available and resident 1 is her own responsible party. Resident 2: No. No family available and resident 2 is his own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed incident reports and complied with law enforcement.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40287	A. BUILDING: _____ B. WING _____	C 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEKKY CARE SERVICES PROFESSIONAL C(	1160 CHICAGO AVENUE ST PAUL PARK, MN 55071

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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: HL402876401C/HL402878742M HL402871800C/HL402871240M On February 4, 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 was 1 resident receiving services under the provider's Assisted Living license. The following correction orders are issued for HL402876401C/HL402878742M, tag identification 630, 1290, 2360. The following correction orders are issued for HL402871800C/HL402871240M, tag identification 630, 1290.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to adequately assess and develop individual abuse prevention plans (IAPP) with specific interventions in place to reduce risks and vulnerabilities three of three residents (R1 R2, R3) reviewed. R1 started a fire in his room. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 admitted to the licensee February 1, 2024. R1's diagnoses included bipolar disorder and substance abuse. R1's service plan dated January 31, 2024, indicated R1 received	0 630		

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0 630	Continued From page 2 medication management. R1's service plan identified goals including assuring safety but did not include safety interventions. R1's assessment dated August 14, 2024, indicated R1 had a history of smoking in his room and chose not to use the designated smoking area, and previously burned his bed sheet with a cigarette. The assessment identified R1 as able to safely use a lighter or matches and smoking materials but did misuse it when smoking in his room. An incident report dated December 5, 2024, indicated R1 had an episode of experiencing auditory and visual hallucinations the Federal Bureau of Investigations (FBI) had surrounded the house. R1 was yelling and barricading the doors. The incident report identified R1's behaviors as concerning and indicated staff would continue closely monitoring his mental state and medication compliance for safety of himself and others. An incident report dated December 10, 2024, indicated R1 threatened to hit staff and others with a metal iron and had delusions and paranoia about the FBI. An incident report dated January 15, 2025, indicated R1 left the licensee, informing staff he was going to the mall. The report indicted staff presumed R1 was heading to a location he typically acquired methamphetamine. R1 did not return to the licensee. The licensee notified law enforcement and filed a missing person report. R1 fled from law enforcement when he was found. Later, R1 showed up at homeless shelter and the director contacted the licensee. The director recommended to the licensee R1 needed a mental health worker and intensive residential treatment program for 90 days to address	0 630		

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0 630	Continued From page 3 substance abuse. R1's IAPP dated January 15, 2025, indicated R1 had a history of abusive behavior towards others and risk factors including mental health conditions and drug-induced psychosis. The IAPP indicated R1 sometimes did not have insight to his mental illness when experiencing drug-induced psychosis and not mentally stable. The IAPP section for self-abuse, including engaging in self-injurious behaviors was left blank. R1's record failed to include interventions to help reduce the risk for fires or to ensure safety due to R1 smoking in his room. R1's service delivery record dated January 2025, included behavior monitoring. Behavior monitoring included for aggression, destructive property, yelling, banging on walls, hallucinations, signs of drug induced paranoia, and concerns of smoking in his room. However, the service delivery record and IAPP failed to include specific direction of interventions for unlicensed personnel (ULP) to take when R1 experienced behaviors. An incident report dated January 19, 2025, indicated smoke detectors went off early in the morning. Smoke came from R1's room and filled the entire common area. Staff responded and went to R1's room. The staff member instructed R1 to open his door, but he refused and had barricaded the entrance to his room. R1 became increasingly agitated and stated it was not a big deal and he was okay. The staff member proceeded to use an extra key to gain access. Due to the extent of the smoke and potential fire hazard, staff forced entry into the room. R1 had been smoking in his room and staff found drug paraphernalia and what appeared to be illegal drugs. R1 appeared confused, restless, and	0 630		

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0 630	Continued From page 4 disoriented. R1 stated the FBI started the fire. Staff put out the fire, and resident 2 called 911 and evacuated from the building. A fire department's fire report dated January 19, 2025, indicated although they received an initial notice of smoke at the facility, but it had been canceled. They were then called by law enforcement to come to the facility due to a resident knocking over a candle in his room. The candle ignited a plastic laundry basket filled with mail. This burned into the wood floor and caused smoke. The burn extended into the flooring, which the fire department extinguished. During an interview February 5, 2025, at 9:34 a.m., registered nurse (RN)-A stated R1 had a history of smoking in his room. R1 had already received a warning and a thirty (30) day notice. The morning of the incident, RN-A received a call from ULP-C, stating R1 started a fire. He had been trying to get R1 and R2 out of the facility and put out the fire. R1 also had a history at the facility of removing the smoke detector from his room, as well as locking and barricading his door closed. Interventions in place included informing R1 he could not smoke in his room, giving a warning, placing him on a probationary period, and calling law enforcement when they thought he appeared to be under the influence of illegal drugs. The licensee also tried to perform safety checks when they thought he had been using drugs. RN-A stated they tried to keep R1's lighter, but he purchased more when he left the facility. R2 R2 admitted to the licensee November 26, 2024. R2's diagnoses included anxiety. R2's service plan dated November 26, 2024, indicated she received assistance with monitoring for	0 630		

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0 630	Continued From page 5 heightened anxiety. R2's service plan identified goals including assuring safety but did not include safety interventions. R2's IAPP dated November 26, 2024, indicated R2 had a history of abusive behaviors towards others. The IAPP did not identify any specific goals or interventions to address R2's vulnerabilities and minimize the risk of abuse. R3 R3 admitted to the licensee December 2, 2024. R3's diagnoses included schizoaffective disorder. R3's service plan dated December 2, 2024, indicated he received assistance with monitoring for heightened anxiety. R3's service plan identified goals including assuring safety but did not include safety interventions. R3's IAPP dated December 2, 2024, included a section titled Physical Abuse. Within the section, RN-A answered "no" to the question asked if R3 was susceptible to physical abuse. The IAPP did not identify R3 as having inappropriate interactions with others or as being verbally/physically abusive to others. The IAPP did not identify any specific goals or interventions to address R3's vulnerabilities and minimize the risk of abuse. The IAPP indicated the licensee did not have knowledge of R3 committing a violent crime or act of physical aggression toward others. An incident report dated January 13, 2025, indicated R3 verbally threaten to physically assault other residents. R3 contacted law enforcement to complain about his peers. Law enforcement talked with residents and left. Immediately after law enforcement left, R3 threatened to physically harm a female peer [R2], approaching her closely, displaying anger and	0 630		

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0 630	Continued From page 6 irritability. R2 said she would defend herself. R3 called law enforcement again. R3 was arrested and taken to jail, determined to be the aggressor. A law enforcement report dated January 13, 2025, indicated law enforcement responded to reports of verbal dispute. R2 threatened R3 with use of pepper spray. R3 confronted R2 who was sitting on the couch, gesturing towards R2 while yelling and using profanity. R2 warned R3 if he did not move away she would pepper spray him. R3 told R2 he would "break her in half" before she could spray him. The facility owner (OW)-B, onsite, told law enforcement R3 had exhibited verbal aggression towards other residents and pushed a male resident at one time. Law enforcement took R3 into custody. R2 stated because of R3's verbal outbursts, she carried pepper spray. During an interview on February 4, 2025, at 12:06 p.m., R2 stated when law enforcement first arrived, R3 complained about R1. R2 stated she told law enforcement R1 was not the problem, R3 was. R3 told R2 to shut her mouth and law enforcement told R3 not to talk to her that way. After law enforcement left, R3 told R2 he did not care what law enforcement said, he would snap her in half before she could spray him with pepper spray. R2 stated OW-B was present and just sat there and said nothing. During an interview on February 5, 2025, at 9:34 a.m., RN-A stated R3 had anger issues and could be triggered easily. After the incident, she completed education with staff on how to redirect residents during verbal altercation and how to de-escalate situations. During an interview on February 5, 2025, at 10:56	0 630		

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0 630	Continued From page 7 a.m., OW-B stated during the altercation with R2 and R3, he instructed R2 to go downstairs and take a nap. He told R3 to take his medications. During an interview on February 21, 2025, at 10:03 a.m., R3 confirmed the same information as the law enforcement report and his verbal threat to R2. He stated they had a loud verbal confrontation. R3 stated OW-B had been there the whole interaction and did nothing. R3 stated OW-B was careless, negligent, lacked supervision and lacked protection from an attempt of assault upon him. R3 stated when law enforcement arrived, OW-B did not interact with them, sat in a chair and did nothing. R2 and R3's IAPPs failed to be updated after the incident on January 13, 2025. During an interview March 25, 2025, at 10:00 a.m. RN-A stated she completed IAPPs upon admission, then with 14 day assessments, 90-day assessments, and as needed. "As needed" meant when any incident happened, causing a need to update the IAPP. RN-A stated if a vulnerability was identified, interventions would be identified to help reduce the risk. The licensee's policy Individual Abuse Prevention Plan dated January 1, 2024, indicated the licensee would develop and implement an IAPP for each vulnerable adult. The plan would contain an individualized review or assessment, including specific measures to be taken to minimize the risk of abuse to that person or other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (volunteer (VOL)-C) had a cleared background study before having access to residents. This had the ability to affect all residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee February 1, 2024.	01290		

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01290	Continued From page 9 R1's diagnoses included bipolar disorder and substance abuse. R1's service plan dated January 31, 2024, indicated R1 received assistance with reminders to perform grooming and dressing and medication administration. R1's service plan identified goals including assuring safety. R1's assessment dated August 14, 2024, indicated R1 had a history of smoking in his room and once burnt his bedsheet with a cigarette. R2 admitted to the licensee November 26, 2024. R2's diagnoses included anxiety. R2's service plan dated November 26, 2024, indicated she received assistance with monitoring for heightened anxiety. R1's service plan identified goals including assuring safety. During an onsite visit February 4, 2025, at 2:47 p.m., the investigator requested VOL-C's personnel file from registered nurse (RN)-A. During an interview February 4, 2025, at 3:29 p.m., RN-A stated she could not find VOL-C's file and needed to check her office. During email correspondence February 10, 2025, at 11:20 a.m., RN-A indicated owner (OW)-B hired VOL-C to volunteer on October 10, 2024. RN-A indicated she could not locate VOL-C's background study clearance results, so she ran a background check February 7, 2025. The licensee's staff roster, undated, indicated VOL-C started working as a volunteer at the licensee December 25, 2024. The licensee's staff schedule for January 2025, indicated VOL-C had been scheduled January 4, 2025, and January 19, 2025.	01290		

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(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
01290	Continued From page 10 During an interview February 12, 2025, at 9:33 a.m. VOL-C stated he started working as an unpaid volunteer around November 2024. He helped with mostly everything except signing documentation and medications. VOL-C stated he normally worked with a staff member, but on January 19, 2025, the staff member called in. VOL-C stated he was not supposed to be alone that shift. The licensee-provided policy Background Studies, dated January 20, 2024, indicated the licensee would conduct a Minnesota Department of Human Services (DHS) background study on all employees and volunteers. The policy also indicated no employee could provide direct services and have independent direct contact with any residents until acceptable result of the background study had been received. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial 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 three resident(s) reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40287	A. BUILDING: _____ B. WING _____	C 02/04/2025

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02360	Continued From page 11 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(s) for details.	02360		