Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356646505M
Compliance #: HL356642231C

Date Concluded: December 29, 2023

Name, Address, and County of Facility Investigated:
Kingsway Healthcare Services
9248 Queens Gardens
Brooklyn Park, MN 55443-1641
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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

Finding: Not Substantiated

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 the facility neglected the resident, when staff failed to assess the resident after the resident reported methamphetamine use, a seizure, and fall with head injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's plan of care was followed, and staff immediately responded to a report of a change in the resident's condition.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and the resident's case manager. The investigation included review of medical records, facility

documentation, and facility policies and procedures. At the time of the onsite visit, the investigator observed staff interaction and communication with residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, psychosis, and diabetes. The resident's service plan included assistance with daily safety checks, behavior monitoring, assistance with activities of daily living, and medication management services. The resident's assessment identified vulnerabilities of agitation in new environments, wandering in and out of the facility without a history of elopement, and a history of substance abuse.

The day prior to the incident, the resident's medical record indicated staff observed the resident had difficulty sleeping, was red in the face, profusely sweating, and the resident informed staff how much she enjoyed "meth." The medical record also indicated the resident contacted her case manager due to difficulties with abstaining from substance use.

The next evening, the resident reported to staff that she had a seizure and fell and requested to go to the hospital. Staff contacted emergency medical services (EMS) to have the resident transported to the hospital for further evaluation.

Hospital records indicated the resident reported recent methamphetamine use and a history of seizures to hospital staff. Hospital staff documented a small injury was observed on the resident's forehead and x-rays obtained showed no evidence of fracture. No signs of seizure activity were exhibited during the hospital stay and the resident was transported back to the facility.

Facility nursing staff who worked at the time of the incident were no longer employed at the facility and were not available for interview.

During an interview, the resident's case manager indicated she was informed of the incident and a referral was made for substance abuse resources and therapy with an outside agency.

In conclusion, neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.

Action taken by facility:
Facility staff responded to the resident's report of a change in condition and nursing staff completed a follow-up assessment of the incident, fall, and injury.

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
	35664	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY HEALTHCARE SVCS LLC	9248 QUEENS GARDEN N BROOKLYN PARK, MN 55443

(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: #HL356646537C/#HL356648928M #HL356642231C/#HL356646505M On November 15, 2023, 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 5 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL356646537C/#HL356648928M, tag identification 0630 and 2350.	0 000		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an	0 630		

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0 630	Continued From page 1 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 ensure an individual abuse prevention plan (IAPP) was developed based on an individual's susceptibility to abuse for one of four residents (R1) with records reviewed. 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, but was not likely to cause 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's medical record was reviewed. R1's diagnoses included borderline intellectual functioning. R1's service plan dated April 1, 2023, indicated R1 received daily assistance with safety checks, behavior monitoring, medication management, and reminders for bathing and dressing needs. R1's assessment dated September 12, 2023,	0 630		

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0 630	Continued From page 2 signed by registered nurse (RN)-B, indicated R1 had no physically aggressive behaviors. R1's care plan dated September 12, 2023, signed by RN-B, indicated R1 was at risk to abuse other vulnerable adults due to mental and cognitive status. The care plan indicated R1 had a vulnerability in the area of physical aggressiveness but lacked interventions for physical aggression. R1's vulnerability assessment dated September 12, 2023, signed by RN-B, indicated R1 did not have physically aggressive behaviors. R1's September 2023 individual abuse prevention plan (IAPP) did not identify physically agressive behaviors, R1's risk of abuse to others, or measures to minimize the risk of abuse. An incident report dated October 2, 2023 at 5:30 p.m., indicated R1 had a physical altercation with unlicensed personnel (ULP)-C, which resulted in R1 pulling ULP-C's hair out and R1 sustained a bite from ULP-C on the left index finger. Following the October 2, 2023 incident with ULP-C, R1's IAPP was not updated. During an interview with RN-B on November 29, 2023, at 9:43 a.m., RN-B stated she did not know why R1's IAPP was not updated. RN-B felt that interventions were already in place prior to the incident. The licensee's Vulnerable Adult Policy, dated August 1, 2023, indicated the licensee was required to develop individualized vulnerable adult abuse prevention plans to identify vulnerable risks and develop measures to minimize maltreatment	0 630		

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0 630	Continued From page 3 based on identified information. The licensee's provided Abuse Prevention Plan Policy indicated the resident would be assessed for their susceptibility to abuse by other individuals and to minimize abuse. The policy indicated the resident's plan of care would identify risks and resident/caregivers interventions to minimize those risks and assure safety in the licensee. The licensee's undated Nursing Assessment and Reassessment of Residents Policy included: (e) An assessment of the resident's areas of vulnerabilities and susceptibility to maltreatment. The information would be used to develop an individual abuse prevention plan that identifies measures taken to minimize the risk of maltreatment to the resident. No further information provided. TIME PERIOD TO CORRECT: Seven (7) days	0 630		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four residents (R1) was treated with courtesy and respect when an unlicensed personnel (ULP)-C took R1's personal property, bit R1 during a physical altercation and locked R1 out of the facility while calling 911.	02350		

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02350	Continued From page 4 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). Findings include: R1's medical record was reviewed. R1's diagnoses included borderline intellectual functioning. R1's service plan dated April 1, 2023, indicated R1 received daily assistance with safety checks, behavior monitoring, medication management, and reminders for bathing and dressing needs. R1's nursing assessment dated September 12, 2023, signed by registered nurse (RN)-B, indicated R1 had a history of agitation, paranoia, verbal aggression, anxiety, depression, and a history of smoking but wanted to start smoking a vape inhaler. R1's individualized abuse prevention plan (IAPP) dated September 12, 2023, signed by RN-B, included interventions for behavior vulnerabilities included redirection, calling licensee management or law enforcement immediately. An incident report dated October 2, 2023 at 5:30 p.m., indicated 911 was called after R1 retrieved a smoking vape from the licensee's mailbox. An unlicensed personnel (ULP)-C took the vape inhaler away from R1 resulting in a physical	02350		

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02350	Continued From page 5 altercation. The incident report indicated R1 began striking ULP-C, begging for the vape inhaler back when ULP-C bit R1 to get free. R1 was then transported to the hospital. R1's hospital records indicated R1's left index finger included a superficial abrasion (affecting only the top layer of skin) and was treated with antibiotics to prevent infection from a human bite. Licensee provided doorbell video footage from the date of the incident showed the AP push R1 against the building while holding the vape inhaler. The AP then rolled to the sidewalk where R1was on top of the AP stating: "give me my vape, give me my vape," and "OW!" "you bit me huh?" "you bit me." Facility documentation regarding the incident, dated October 3, 2023, at 7:08 p.m., sent from ULP-C to licensed assisted living director (LALD)-A, included an account from ULP-C of what occurred during the physical altercation with R1. The document indicated ULP-C bit R1 in a panic after R1 would not let ULP-C's hair go and when ULP-C broke free, she went into the building to call the police. ULP-C locked R1 outside while she called for police assistance. Review of ULP-C's employee record indicated ULP-C was hired on July 3, 2023. ULP-C's employee record indicated ULP-C completed all required orientation training including, Resident Bill of Rights, Vulnerable Adult Policy, and Effective Approches and Problem Solving Techniques for Dealing with Challenging Behaviors Course. During an interview on November 22, 2023, at 1:37 p.m., licensed assisted living director,	02350		

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02350	Continued From page 6 (LALD)-A, stated R1 was able to use the vape inhaler in the licensee's designated smoking areas. LALD-A did not know why ULP-C took R1's vape inhaler away and stated when they interviewed ULP-C to ask why she took R1's vape inhaler, ULP-C hung up the phone. During an interview on November 29, 2023 at 5:10 p.m., R1 stated she retrieved the vape inhaler sent to her by her mother, from the licensee's mailbox when ULP-C came outside and took the vape inhaler away while R1 was using it. R1 had previously been informed by LALD-A that she could use the vape inhaler outside. R1 stated when ULP-C started grabbing the vape inhaler, R1 told ULP-C to "back off." R1 stated when ULP-C took the vape inhaler, the two got into a fight and ULP-C bit her left index finger and it started to bleed. R1 stated ULP-C then threw the inhaler down and when R1 went to retrieve it, ULP-C went into the facility and called police. A licensee provided Resident Bill of Rights indicated residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02350		