

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356648928M
Compliance #: HL356646537C

Date Concluded: December 29, 2023

Name, Address, and County of Licensee

Investigated:

Kingsway Healthcare Services 10/3/2023
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.

Initial Investigation Allegation(s):

An unlicensed personnel/alleged perpetrator (AP) abused resident when she bit a resident after taking the resident's property, then locked the resident out of the facility while the AP called 911.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. After the unlicensed personnel/alleged perpetrator (AP) grabbed the resident's smoking vape inhaler, a physical altercation ensued, and the AP bit the resident in self-defense. The AP then contacted emergency medical services (EMS) and facility management, and the resident was transported to the hospital for evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed case workers and contacted law enforcement. The investigation included review of medical records, facility

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

The resident resided in an assisted living facility. The resident's diagnoses included borderline intellectual functioning, Grave's Disease, and major depressive disorder. The resident's service plan included assistance with daily safety checks, behavior monitoring, activities of daily living, and medication management services. The resident's assessment identified vulnerabilities of a history of self-harm, multiple elopements, verbal aggression, and agitation.

Facility driveway video footage from the day of the incident showed the resident holding a vape inhaler. The AP was seen trying to retrieve the vape inhaler from the resident.

Facility doorbell video footage showed the AP near the resident against the facility's siding. The AP then rolled to the sidewalk and the resident is seen on top of the AP stating: "give me my vape, give me my vape." The resident is then heard yelling "ow, you bit me huh, you bit me."

There was no further video footage available of the incident.

Facility documentation indicated once the resident let go of the AP, the AP contacted law enforcement and facility management to inform them of the incident.

Law enforcement arrived at the facility and interviewed the AP. The AP informed law enforcement she bit the resident out of self-defense. Law enforcement transported the resident to the hospital for further evaluation. The case was closed, and no charges were filed.

The resident's hospital records indicated the resident reported that she was bit on her left index finger by facility staff. Hospital staff documented a superficial abrasion (affecting only the top layer of skin) on the resident's left index finger that was cleansed and treated. An antibiotic was prescribed to prevent infection to the area and the resident returned to the facility.

During an interview, the resident stated after retrieving and opening a "vape" her mother sent her, the AP came out of the facility and tried grabbing the vape while the resident was using it. The resident stated she told the AP to "back-off" and the AP kept attempting to grab the vape inhaler. The resident started striking the AP and during the physical altercation, the AP bit the resident's left index finger, and it started bleeding. The resident stated when the AP got a hold of the vape inhaler, she threw it in the woods and told the resident to go and get it. The AP then went into the facility and called 911.

During an interview, facility administrative staff stated the AP reported the physical altercation to them after calling 911 for assistance. Following the incident, the AP resigned from her position. When facility administrative staff questioned the AP on why she took the resident's vape inhaler, the AP hung up the phone. Facility administrative staff stated the resident was allowed to use smoking vape inhalers in designated smoking areas and did not understand why

the AP had taken the inhaler. The administrative staff also stated there was not a policy in place that indicated residents were not allowed to retrieve mail from the facility mailbox.

The AP declined to be interviewed.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(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;

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: No, the AP declined to be interviewed.

Action taken by facility:

A facility incident report was completed by facility staff and the AP, and a follow-up assessment of the resident's injury was completed by facility nursing staff. The incident was reported to state agency and staff were re-trained on de-escalation tools, incident reporting, and resident rights. The AP is no longer employed at the facility.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35664	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2023
NAME OF PROVIDER OR SUPPLIER KINGSWAY HEALTHCARE SVCS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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 aggressive 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 R1 was 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			