Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL28604033M
Compliance #: HL28604034C

Date Concluded: June 23, 2021

Name, Address, and County of Licensee Investigated:
Summit Hill Senior Living
820 Lilac Drive N, Suite 170
Golden Valley, MN 55422
Hennepin County

Name, Address, and County of Housing with Services location:
Summit Hill Senior Living
1824 Old Hudson Rd
St. Paul, MN 55119
Ramsey County

Facility Type: Home Care Provider

Investigator's Name: Shannan Stoltz, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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: A facility-contracted security guard physically abused the client when the guard tackled the client to the floor.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment when he physically assaulted the client. Video footage of the altercation between the AP and the client showed the AP forcibly took the client to the floor, after the client had turned and started to walk away from the AP, and then restrained the client on the floor. As a result, the client experienced rib pain and had to seek medical attention. The home care provider was also responsible for the abuse because they did not complete a background study on the AP prior to allowing the AP to start work at their facility, although the AP routinely provided behavioral interventions for clients. The AP was disqualified to work around vulnerable adults.

An equal opportunity employer.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. This investigation also included an interview with the client. In addition, the investigator viewed videotaped surveillance footage of the confrontation between the client and the AP. The investigation also included an onsite visit for observations, review of medical records, and review of facility policies and procedures.

The client's medical record was reviewed. The client's diagnosis included major depressive disorder, adjustment disorder with mixed disturbance of emotions and conduct, and alcohol dependence. The client's service plan indicated he received services for medication administration, behavior monitoring, and safety checks.

Late one evening, the AP, a facility-contracted security, arrived on the premises for his shift. The AP advised facility staff there were dangerous things going on in the community and for safety reasons, the AP planned to lock the facility's front doors at 10:00 p.m.

Sometime after 10:00 pm, the client came down from his apartment and wanted to go outside. The client was advised that the front doors were to remain locked to ensure facility safety. The client took issue with not being allowed to go outside and started yelling, cursing, and using racial slurs towards staff and the AP; the incident escalated.

During an observation of facility surveillance tapes of the incident, the client is viewed standing behind the AP speaking to the AP's back. The surveillance audio is low, and the conversation cannot be heard. The client turned around and started to walk away. The AP then turned around towards the client, grabbed the client from behind, and body-slammed the client to the floor. The surveillance tape showed that the AP held the client down in the prone position for approximately 20 minutes, until law enforcement arrived at the facility. The surveillance tape showed that during this time, the client struggled to get up and the AP struggled to keep the client down.

During an interview with the client, he stated that the AP "got in my face" and then "did a take-down move on me." The client stated that while he pinned to the floor, the AP "punched me in the ribs the entire time until police got there." The surveillance tape showed the AP's "take-down move" on the client, but did not show the other parts of the client's recollection of the altercation. The client stated that facility staff had previously involved the AP in disputes between the client and other clients.

A facility provided document of AP's written report of the altercation indicated that before the altercation, the client "pushed" and "chest-butted" the AP. This document indicated that, "It was at this point that I had pulled Resident to the ground to restrain him." This document contradicted what the surveillance video showed. This document indicated that after the altercation, the AP continued to work at the facility until 2:00 a.m. the next morning.

During an interview, the executive director, stated the facility contracted with a security agency several months ago due to increased crime in the neighborhood. The executive director stated he had not performed a background study on the AP prior to the AP's start date at the facility.

Information on the State of Minnesota background studies website indicated the AP was disqualified from working with vulnerable adults several years prior.

No contact information for the AP was provided by the security company, and the home care provider did not have contact information for the AP. As a result, the AP was not interviewed. Phone calls made to other staff who worked the night of the altercation were not returned.

The facility failed to immediately report the client's maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). Records indicated the report was made three days after the altercation occurred.

In conclusion, abuse was substantiated. Surveillance footage showed the AP forcibly take the client to the ground and restrain the client, after the client had turned and started to walk away. As a result, the client experienced pain and had to seek medical attention.

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:
(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;

(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; and

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: No; AP could not be reached.

Action taken by facility:
Requested the security guard not return to their facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Ramsey County Attorney
Saint Paul City Attorney
Saint Paul Police Department (Case # 21-041948)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28604	A. BUILDING: ____ B. WING ____	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	**1824 OLD HUDSON ROAD SAINT PAUL, MN 55119**

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On June 2, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL28604033M / HL28604034C. At the time of the investigation, there were 87 clients receiving services under the comprehensive license. The following correction orders are issued for #HL28604033M/HL28604034C, tag identification 0325, 0715, 0805 and 2015.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested?for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure 1 of 87 clients reviewed were free from maltreatment. Client #1 was abused. Findings include: On June 2, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility and an individual staff person were responsible for the maltreatment, in connection with incidents, which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325.	
0 715 SS=I	144A.476, Subd. 2 Employees, Contractors, and Volunteers Subd. 2.Employees, contractors, and volunteers. (a) Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring	0 715		

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0 715	Continued From page 2 self-disclosure of criminal conviction information. (b) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not subject the home care provider to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview, record review, and facility surveillance tapes, the licensee failed to ensure a background study was completed for one of one contractors reviewed. The licensee contracted with a third-party security agency to provide a security guard for clients and the facility grounds, and routinely used this security guard for client monitoring and behavioral interventions. The licensee had not completed a background study on the security guard, and State of Minnesota records indicated the security guard was disqualified to work around vulnerable adults. The security guard was observed on surveillance tapes forcibly taking a client (C1) to the ground and restraining C1. C1 later had complaints of rib pain and had to seek medical attention. This violation caused harm to C1 and had the potential to cause harm to all 87 clients at the location. This practice resulted in a level three violation (a violation that harmed a client'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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).	0 715		

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0 715	Continued From page 3	0 715		

The findings include:

On March 1, 2021, at approximately 10:30 pm, security guard and alleged perpetrator (AP)-D body-slammed C1 to the ground, then held C1 down until law enforcement arrived at the facility.

During a facility visit on June 2, 2021, at 10:00 am, this investigator viewed facility surveillance tapes which showed AP-D, as he stood in a doorway in the facility lobby. C1 stood right behind AP-D and they both faced the same direction. C1 appeared to say something to AP-D's back, but conversation cannot be heard due to low audio quality. The tape showed that C1 turned around and took a step to walk away. AP-D then turned around, grabbed C1, and slammed C1 to the ground. The tape showed that AP-D held C1 down in the prone position (on the floor), for approximately 20 minutes until law enforcement arrived. The tape showed that during the time AP-D held C1 down, C1 struggled to get up and AP-D struggled to hold C1 down.

Facility provided document of AP-D's report of the altercation between himself and C1, dated March 2, 2021, indicated that after the altercation, AP-D continued to work at the facility until 2:00 am the next morning. AP-D's account indicated that C1 "pushed" and "chest-butted" AP-D, and that "It was at this point that I {AP-D} had pulled Resident {C1} to the ground to restrain him." AP-D's written account of the altercation contradicted what the surveillance video showed. The third-party security agency AP-D works for refused to supply any information on AP-D.

Client #1's (C1) medical record was reviewed. C1's medical diagnoses included major depressive disorder, adjustment disorder with

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0 715	Continued From page 4	0 715		

mixed disturbance of emotions and conduct, and alcohol dependence. C1's service plan indicated C1 received medication management, behavior monitoring, and safety checks. C1's record indicated C1's primary care provider ordered x-rays after C1 complained of rib pain due to the altercation. The x-rays were unremarkable with no indication of an abnormality.

During a facility visit on June 2, 2021, at 10:30 am, a copy of the alleged perpetrator (AP)-D's background study was requested, but not received.

During an interview on June 18, 2021, at 1:40 pm, with executive director (ED)-A, he stated his facility had not run a background study on AP-D. The ED-A stated he could not provide any other information on AP-D, except for his name. ED-A stated AP-D's security company refused to release any information about AP-D after the altercation, and no one at the facility had gathered information on AP-D prior to the incident. ED-A stated he was unsure of how long AP-D had worked at the facility, but that it had been for a few months.

In an email dated June 18, 2021, at 3:55pm, from the security agency's attorney, the attorney confirmed AP-D's date of birth.

In a review of the Minnesota Department of Health NetStudy's website, information indicated that AP-D was Disqualified on February 2, 2018.

During an interview on June 21, 2021, at 8:03 am, with C1, he stated AP-D "got in my face" and "then the security guard did a take-down move on me." C1 stated that while AP-D had C1 pinned to the floor, AP-D "held me down for another 20

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0 715	Continued From page 5	0 715		

minutes and punched me in the ribs the entire time until police got there." (The surveillance tape supported that AP-D performed "a take-down move" on C1, but did not show the other parts of C1's verbalized recollection of the altercation.) C1 also stated that staff constantly got AP-D involved in conflicts involving himself (C1), and other clients at the facility.

Phone calls made to unlicensed personnel who worked the night of the incident were not returned.

The security agency refused to supply any information on AP-D, to include a contact phone number, and this investigator had no way to contact AP-D.

The licensee's policy for Supplemental Staff and Contract Staff Qualifications, dated July 10, 2017, indicated "Individual Contractors who are excluded from licensure under MN Statute 144A.471 to provide home care services may be employed by RM Management, but the individual contractors must meet the same requirements as those required for personnel employed by RM Management".

The licensee's policy for Background Checks, dated January 27, 2017, indicated "RM Management will conduct a Minnesota Department of Human Services Background Study on all employees of RM Management who will have independent, unsupervised contact with tenants or clients of RM Management".

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 805	Continued From page 6	0 805		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors	0 805		

Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

This MN Requirement is not met as evidenced by:
Based on interview, document review, and facility surveillance tapes, the licensee failed to immediately report a maltreatment allegation to the State Agency for one of one clients (C1) reviewed, when a facility security guard took C1 to the floor and then restrained C1, without an order to do so or an immediate threat to safety. C1 later had complaints of rib pain and had to seek medical attention.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On March 1, 2021, at approximately 10:30 pm, security guard and alleged perpetrator (AP)-D body-slammed C1 to the ground, then held C1

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0 805	Continued From page 7 down until law enforcement arrived at the facility. C1's medical record was reviewed. C1's medical diagnoses included major depressive disorder, adjustment disorder with mixed disturbance of emotions and conduct, and alcohol dependence. C1's service plan indicated C1 received medication management, behavior monitoring, and safety checks. C1's record indicated x-rays were performed after C1 complained of rib pain due to the altercation. The x-rays were unremarkable with no indication of an abnormality. During a facility visit on June 2, 2021, at 10:00 am, this investigator viewed facility surveillance tapes which showed AP-D body slam C1 to the ground, after C1 had turned to walk away from AP-D. The tapes further showed that AP-D held C1 down (on the floor) for approximately 20 minutes until law enforcement arrived. During a review of the Minnesota Adult Abuse Report Center (MAARC) complaint for this incident, the record indicated the altercation occurred on March 1, 2021, at approximately 10:30 pm. This record further indicated the licensee did not report the possible abuse until March 4, 2021. During an interview on June 2, 2021, at 10:30 am, with executive director (ED)-A, he acknowledged that the facility was late to make a MAARC report, but stated the reason was the security company's failure to provide AP-D's contact information. ED-A stated he did not have any information on AP-D, other than his name, even though AP-D had worked at the facility for several months. ED-A stated the licensee had not requested any information on AP-D prior to the	0 805		

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0 805		0 805		

Continued From page 8

altercation with C1, to include a background study. ED-A stated that after the altercation between AP-D and C1, he requested information on AP-D from the security company, but they refused to provide any information.

In a review of the Minnesota Department of Health NetStudy's website, information indicated that AP-D was Disqualified on February 2, 2018, to work around vulnerable adults.

During an interview on June 21, 2021, at 8:03 am, with C1, he stated AP-D "got in my face" and then the "security guard did a take-down move on me". C1 stated that while AP-D had C1 pinned to the floor, AP-D "held me down for another 20 minutes." C1 also stated that staff constantly got AP-D involved in conflict-type issues involving himself (C1), and other clients at the facility.

Facility provided document of AP-D's report of the altercation, dated March 2, 2021, indicated that after the altercation, AP-D continued to work at the facility until 2:00 am the next morning. AP-D's account indicated that C1 "pushed" and "chest-butted" AP-D, and that "It was at this point that I {AP-D} had pulled Resident {C1} to the ground to restrain him." AP-D's written account of the altercation contradicted what the surveillance video showed. The third-party security agency AP-D works for refused to supply any information on AP-D.

The licensee's policy Maltreatment-Communication, Prevention, and Reporting, dated May 1, 2020, indicated, "Immediate report to the MAARC required: Upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, neglect, or financial exploitation, the RN or

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0 805	Continued From page 9 Executive Director shall immediately make an oral report to the MAARC", and "IMMEDIATELY means as soon as possible and no longer than 24 hours". The licensee's policy for Supplemental Staff and Contract Staff Qualifications, dated July 10, 2017, indicated "Individual Contractors who are excluded from licensure under MN Statute 144A.471 to provide home care services may be employed by RM Management, but the individual contractors must meet the same requirements as those required for personnel employed by RM Management". The licensee's policy for Background Checks, dated January 27, 2017, indicated "RM Management will conduct a Minnesota Department of Human Services Background Study on all employees of RM Management who will have independent, unsupervised contact with tenants or clients of RM Management". TIME PERIOD FOR CORRECTION: Seven (7) days	0 805		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission,	02015		

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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
02015	Continued From page 10 unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572,	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28604	A. BUILDING: ______ B. WING ______	C 06/02/2021

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subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview, document review, and facility surveillance tapes, the licensee failed to immediately report a maltreatment allegation to the State Agency for one of one clients (C1) reviewed, when a facility security guard took C1 to the floor and then restrained C1, without an order to do so or an immediate threat to safety. C1 later had complaints of rib pain and had to seek medical attention.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On March 1, 2021, at approximately 10:30 pm, security guard and alleged perpetrator (AP)-D body-slammed C1 to the ground, then held C1 down until law enforcement arrived at the facility.

C1's medical record was reviewed. C1's medical diagnoses included major depressive disorder, adjustment disorder with mixed disturbance of emotions and conduct, and alcohol dependence. C1's service plan indicated C1 received medication management, behavior monitoring,

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and safety checks. C1's record indicated x-rays were performed after C1 complained of rib pain due to the altercation. The x-rays were unremarkable with no indication of an abnormality.

During a facility visit on June 2, 2021, at 10:00 am, this investigator viewed facility surveillance tapes which showed AP-D body slam C1 to the ground, after C1 had turned to walk away from AP-D. The tapes further showed that AP-D held C1 down (on the floor) for approximately 20 minutes until law enforcement arrived.

During a review of the Minnesota Adult Abuse Report Center (MAARC) complaint for this incident, the record indicated the altercation occurred on March 1, 2021, at approximately 10:30 pm. This record further indicated the licensee did not report the possible abuse until March 4, 2021.

During an interview on June 2, 2021, at 10:30 am, with executive director (ED)-A, he acknowledged that the facility was late to make a MAARC report, but stated the reason was the security company's failure to provide AP-D's contact information. ED-A stated he did not have any information on AP-D, other than his name, even though AP-D had worked at the facility for several months. ED-A stated the licensee had not requested any information on AP-D prior to the altercation with C1, to include a background study. ED-A stated that after the altercation between AP-D and C1, he requested information on AP-D from the security company, but they refused to provide any information.

In a review of the Minnesota Department of Health NetStudy's website, information indicated

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that AP-D was Disqualified on February 2, 2018, to work around vulnerable adults.

During an interview on June 21, 2021, at 8:03 am, with C1, he stated AP-D "got in my face" and then the "security guard did a take-down move on me". C1 stated that while AP-D had C1 pinned to the floor, AP-D "held me down for another 20 minutes." C1 also stated that staff constantly got AP-D involved in conflict-type issues involving himself (C1), and other clients at the facility.

Facility provided document of AP-D's report of the altercation, dated March 2, 2021, indicated that after the altercation, AP-D continued to work at the facility until 2:00 am the next morning. AP-D's account indicated that C1 "pushed" and "chest-butted" AP-D, and that "It was at this point that I {AP-D} had pulled Resident {C1} to the ground to restrain him." AP-D's written account of the altercation contradicted what the surveillance video showed. The third-party security agency AP-D works for refused to supply any information on AP-D.

The licensee's policy Maltreatment-Communication, Prevention, and Reporting, dated May 1, 2020, indicated, "Immediate report to the MAARC required: Upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, neglect, or financial exploitation, the RN or Executive Director shall immediately make an oral report to the MAARC", and "IMMEDIATELY means as soon as possible and no longer than 24 hours".

The licensee's policy for Supplemental Staff and Contract Staff Qualifications, dated July 10, 2017, indicated "Individual Contractors who are

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02015	Continued From page 14 excluded from licensure under MN Statute 144A.471 to provide home care services may be employed by RM Management, but the individual contractors must meet the same requirements as those required for personnel employed by RM Management". The licensee's policy for Background Checks, dated January 27, 2017, indicated "RM Management will conduct a Minnesota Department of Human Services Background Study on all employees of RM Management who will have independent, unsupervised contact with tenants or clients of RM Management". TIME PERIOD FOR CORRECTION: Seven (7) days	02015		