DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL35007001M
Compliance #: HL35007002C

Date Concluded: August 2, 2022

Name, Address, and County of Licensee Investigated:
Midwest Homes, Inc.
2445 10th Avenue South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Substantiated, 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) physically abused the resident when the AP threw a computer mouse at the resident, and it hit her in the head causing a painful bump.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the resident's behavior plan. The AP acknowledged throwing the computer mouse at the resident and hitting her in the head with it during an argument.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's social worker and a former house manager. The investigation included review of the resident's records, policies and procedures, staff schedules, incident reports and a police incident detail report. Also, the investigator observed the resident interact with staff.

The resident lived in an assisted living facility. The resident's diagnoses included borderline personality, anxiety, and intermittent explosive disorder. The resident's service plan included assistance with medication administration and verbal cueing for activities of daily living (ADLs). The resident's assessments indicated she was vulnerable to abuse by others, vulnerable to abusing others and self-abuse. She had a history of destroying property, stealing, substance abuse, verbal and physical aggression towards others and suicidal ideation. The resident's behavior plan instructed staff to: talk with resident, avoid arguing with her, coach her to use coping skills, monitor her from a non-threatening distance if she became verbally or physically aggressive and notify the registered nurse, owner or program manager if the resident's behaviors increased.

The AP stated the resident told the AP she had accessed the internet through a video game and was on Google. The AP told the resident her court order prohibited her from using social media unless it was for a telehealth visit. She reported the incident to the house manager who notified the resident's parole officer.

The next day the AP said the resident was not happy the AP reported her internet use and said, "snitch bitches get stitches" and "snitches get killed on the street". By early evening the AP and resident had argued and it escalated. The resident spit in the AP's face. The AP told the resident to leave her alone, grabbed a computer mouse and threw it at the resident. The mouse hit the resident in the head. The AP and resident gave conflicting information on how far away they were from each other when the AP threw the computer mouse.

The AP left the house, went across the street, and called the owner and then the police. The resident also called the police. Police arrived, but no report was filed. The AP told police she did not want the resident to go to jail.

A second staff member worked that evening but was downstairs watching TV with another resident. Attempts to reach the second staff member were unsuccessful.

During an interview, the AP said tried talking to the resident to calm her down, but the resident was hysterical and threatened her verbally during the shift and eventually spit in her face. The AP said the resident came at her aggressively and she grabbed the computer mouse and threw it. The AP said she did not try to hit the resident.

During an interview, the resident said the AP had been angry all day and threw the computer mouse at her head from "about three inches away." It hit her left side and she had a painful bump on her head for about one week. The resident said the AP threatened to call the police and have her jailed. The resident did not have any photos of the bump and did not go for medical evaluation.

During an interview, a former employee said the resident had a court order banning her from social media. The former employee said it was unusual for the AP to get mad at a resident and there were no previous incidents with her.

During an interview, the social worker said the resident can be a tough person to care for and, spitting on someone is not ok, but staff are trained and should know better.

Review of the AP's training records indicated she successfully completed online training on professional boundaries and vulnerable adults. The AP acknowledged a code of conduct policy that read she would possess a professional attitude on the job; not drink, gamble, swear or fight while on the job.

In conclusion, abuse was substantiated.

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

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, resident is her own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility investigated the incident and documented findings in an incident report and had a team care conference with the resident's social worker and parole officer

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 651-201-4890 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
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL35007002C/#HL35007001M On June 22, 2022, 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 4 clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL35007002C/#HL35007001M, tag identification 0620, 0630, 0730, 2360, and 3000.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 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 surveyors' 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 subd. 1, 2, and 3.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility 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 and record review, the licensee failed to comply with requirements for immediately reporting an incident of maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one residents (R1) reviewed. Unlicensed personnel (ULP)-A threw a computer mouse and hit R1 on the head after R1 spit at ULP-A during an argument. 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). Findings include: R1's diagnoses included fetal alcohol disorder, attention deficit disorder, intermittent explosive disorder, oppositional defiant disorder and anxiety. R1's service plan, dated November 30, 2020, indicated R1 received supervision and cueing for bathing, grooming and oral cares. R1's medication assessment and management	0 620	No further action required.	

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0 620	Continued From page 2 plan, dated November 30, 2020 assessed R1 as unable to safely administer medications at the scheduled times correctly and consistently and would receive medication administration from licensee staff. R1's behavior plan, dated November 30, 2020, instructed staff to talk with R1 privately if she displayed verbal or physical aggression. If R1 threatens self or others, separate R1 and attempt to talk with her about the situation. If there is imminent danger to self or others staff will call police or 911, in all cases in which the program manager, administrator, owner or police are called, an incident report must be completed prior to end of shift. The January 9 through January 15, 2022 staff schedule, listed the January 14, 2022 evening caregiver (4 p.m. to 12 a.m.) as ULP-A. A second staff member listed on the schedule for that shift did not work. ULP-E worked the 4 p.m. to 12 a.m. shift instead. A law enforcement report dated 1/14/2022, indicated: At 18:03:59 an incident was called for an assault in progress. At 18:04:00 just occurred, [client] lives at group home, was hit by staff member. At 18:07:34 staff member calling in states resident spit in her face waiting across street. At 18:18:58 staff is aok with resident tings {sic} being resolved. A progress note, dated January 15, 2022 a 12:03 p.m., indicated a ULP and R1 argued about R1's personal TV being in the livingroom. "She was calling staff bitches and snitches." R1 and staff argued. R1 spit on staff and the police were	0 620		

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0 620	Continued From page 3 called. The progress note did not specify who R1 spit at. ULP-E wrote the progress note. The Incident and Emergency Report, dated January 17, 2022, completed by program manager (PM)-D, included a section called "Required Notifications: completed within 24 hours of discovery or receipt of information that the incident occurred" with check boxes and spaces for dates and times. PM-D checked "legal representative" emailed on 1/17 at 11:15 a.m. "case manager" emailed on 1/17 at 11:15 a.m., "designated emergency contact" on 1/17 at 11:15 a.m. The DHS Licensing Division, MN Office of the Ombudsman, Common Entry Point/Child Protection Agency sections were not checked. The "internal maltreatment report filed" section was also blank. The section titled "Designated Manager review and recommendation" listed a pattern of "accusing behaviors and manipulation" and corrective active action was needed. "Will be discussed with team." During an interview on June 22, 2022, at approximately 10:15 a.m., R1 said ULP-A got mad at her for wanting to call PM-D and yelled at R1 and threatened to call the police and have her jailed. During an interview on June 22, 2022 at 11:15 a.m., the owner and licensed assisted living director (LALD)-C said R1 should not be on social media because of a court order and when ULP-A asked R1 what she was doing on a computer, R1 spit at ULP-A and ULP-A threw the computer mouse at R1. LALD-C said ULP-A "was talked to" about the incident, but was not suspended and there was no staff retraining. There was no documentation in her employment file aboout the incident. LALD-C said she met with R1's care	0 620		

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0 620	Continued From page 4 team and probation officer about the incident but there was no documentation of that meeting. LALD-C said she did not file a MAARC report because PM-D called SW-B and reported the incident to her. During an interview on July 5, 2022 at 10:01 a.m., social worker (SW)-B said R1 can be tough and did spit on staff which is not ok. SW-B said staff are trained on what to do and can't just throw a computer mouse at someone. SW-B said licensee staff did write an internal incident report but they did not file a MAARC report which they should have done. SW-B said she asked LALD-C why ULP-A continued to work at the house after she hit R1 in the head and suggested that ULP-A should not continue to work there. LALD-C told her it was a reflexive reaction by ULP-A to throw the computer mouse. During an interview on July 6, 2022 at 11:02 a.m., R1 said ULP-A threw the computer mouse at the left side of the head and she had a painful bump for a week. R1 said her grandmother was on the phone with her at the time and heard staff yelling at R1. R1 stated ULP-A is a good person and someone she likes, but she went "ape shit" that night. During an interview on July 6, 2022 at 2:31 p.m., program manager (PM)-D said the incident happened in the evening on January 14, 2022. R1 had a court order prohibiting her from using social media and she'd figured out a way to log onto the Internet through a video game. Staff were monitoring her device use, which made R1 angry and it escalated. PM-D stated she had finished her shift at the house and was home about 30 minutes when she go calls from ULP-A and LALD-C about R1's behaviors. PM-D	0 620		

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0 620	Continued From page 5 completed an incident report and called R1's parole officer and SW-B on January 17, 2022. PM-D said she was not trained on MAARC reports and never filed a MAARC report for any incidents, that was up to LALD-C or a case worker. During an interview on July 7, 2022 at 9:45 a.m., ULP-A said on January 13, 2022, she observed R1 playing a video game on the TV. ULP-A said R1 told her she had accessed Google through the video game. ULP-A said that was a violation of R1's probation and she took a photo of R1 on the internet and sent it to the program manager (PM)-D. The next day, January 14, 2022, ULP-A went to work and said R1 was upset because her parole officer had been notified of the probatin violation. ULP-A said R1 threatened her most of the shift and ULP-A tried to get R1 to calm down and stop threatening her but R1 escalated. She asked to speak to PM-D but ULP-A called LALD-C by accident. R1 spit in ULP-A's face and called her names. ULP-A said she just grabbed the computer mouse and threw it at R1 but did not aim at her head, she just wanted R1 to back away from her. ULP-A said ULP-E was downstairs with another resident during the incident so there were no witnesses. ULP-A said LALD-C told her to go home and ULP-E would write a progress note on the incident. ULP-A said she and R1 both cried and apologized. A policy titled Vulnerable Adult Maltreatment - Prevention and Reporting, dated August 1, 2021 indicated Midwest Homes prohibits the maltreatment of residents. Midwest Homes educates clients, family members and staff (mandated reporters) about reporting suspected maltreatment internally and the the Minnesota Adult Abuse Reporting Center (MAARC). Staff	0 620		

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0 620	Continued From page 6 who suspect maltreatment of a resident or who sustained a physical injury not reasonably explained, will contact the Clinical Nurse Supervisor and the Assisted Living Director. If they confirm suspicion on maltreatment they will contact MAARC and such a report must be made no later than 24 hours after the maltreatment was first suspected. Time Period to Correct: SEVEN (7) DAYS	0 620		
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 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 update the individual abuse prevention plan (IAPP) for one of one resident (R1) reviewed. R1's IAPP was not updated after a physical altercation between R1 and unlicensed personnel (ULP)-A. R1 was prohibited from using the internet and ULP-A observed R1 accessing Google through a video game which was a parole violation.	0 630	No further action required.	

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0 630	Continued From page 7 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). Findings include: R1's diagnoses included fetal alcohol disorder, attention deficit disorder, intermittent explosive disorder, oppositional defiant disorder and anxiety. R1's service plan, dated November 30, 2020, indicated R1 received supervision and cueing for bathing, grooming and oral cares. R1 also received medication management. Staff were instructed to refer to R1's IAPP for incidents of physical aggression. R1's IAPP, dated November 30, 2020, assessed: - R1's "self preservation" as susceptible to abuse by other individuals, including other vulnerable adults, abuse included self abuse. The staff plan of action: staff would continue to monitor for and any change in behavior, will call PM, RN or executive director with changes in condition or reports of abuse and follow guidelines for behavior plan. -R1's "behavioral" assessment was lying, making false accusations, self injurious behaviors (SIB), verbal aggression towards others (yelling, swearing, assaultive behavior) and at risk for abusing other individuals including other vulnerable adults. The plan of action: staff to	0 630		

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0 630	Continued From page 8 follow the behavioral plan as well as monitor for changes with mood or changes with level of consciousness and report concerns or suspicions to RN, PM, and director. -R1's "special circumstances" assessment indicated R1 had legal orders and restrictions. The staff plan: R1 has no alone time at home or in community. Staff will prompt and encourage R1 to comply with home/community restrictions. (No detailed restrictions listed.) R1's behavior plan, dated November 30, 2020, instructed staff to talk with R1 privately if she displayed verbal or physical aggression, if R1 threatens self or others, separate R1 and attempt to talk with her about the situation, if there is imminent danger to self or others staff will call police or 911. A progress note, dated January 15, 2022 a 12:03 p.m., indicated an unlicensed personnel and R1 argued about R1's personal TV being in the livingroom. "She was calling staff bitches and snitches." R1 and staff argued. R1 spit on staff and the police were called. The progress note did not specify who R1 spit at. The Incident an Emergency Report, dated January 17, 2022, completed by PM-D, included the section titled "Designated Manager review and recommendation" listed a pattern of "accusing behaviors and manipulation" and corrective active action was needed. "Will be discussed with team." During an interview on June 22, 2022 at 11:15 a.m., the owner and licensed assisted living director (LALD)-C said R1 should not be on social media because of a court order. LALD-C said she	0 630		

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0 630	Continued From page 9 met with R1's care team and probation officer about the incident but there was no documentation of that meeting and any new measures or changes to R1's IAPP after the incident. LALD-C said the nurse was updating all service plans and assessments. R1's initial IAPP from November 30, 2020 was the only IAPP she had currently. During an interivew on July 7, 2022 at 1:01 pm, LALD-C said staff would talk to her if they did not think R1's IAPP was working or needed changes. LALD-C said she was not sure if there was an IAPP policy and would have to check. A policy titled Vulnerable Adult Maltreatment Prevention and Reporting, dated August 1, 2021, read: Midwest Homes, Inc also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. A policy titled Resident Record Documentation, dated August 1, 2021, read: Staff of Midwest Homes, Inc. authorized to document in a resident record will do so for all medications, services, treatments and therapies for each resident. Staff will also document all other important and pertinent information relating to each resident; new problems, resident or family concerns, a change of condition, incidents, family problems. TIME PERIOD TO CORRECT: Seven (7) Days No further action required.	0 630		

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0 730	Continued From page 10	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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	35007	A. BUILDING: _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 730	Continued From page 11 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all records of communications pertinent to the resident's services were included in the record for one of one resident (R1) reviewed. R1's record lacked documentation of a care team meeting after an incident of abuse between R1 and unlicensed personnel (ULP)-A. 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). Findings include: R1's diagnoses included fetal alcohol disorder, attention deficit disorder, intermittent explosive disorder, oppositional defiant disorder and anxiety. R1's service plan, dated November 30, 2020, indicated R1 received supervision and cueing for bathing, grooming and oral cares. R1 also	0 730	No further action required.	

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0 730	Continued From page 12 received medication management. Staff were instructed to refer to R1's IAPP to handle incidents of physical aggression. An Incident Detail Report from the Minneapolis police department indicated on 1/14/2022: At 18:03:59 an incident was called for an assault in progress. At 18:04:00 just occurred, client lives at group home, was hit by staff member. At 18:07:34 staff member calling in states resident spit in her face waiting across street. At 18:18:58 staff is aok with resident tings {sic} being resolved. A progress note, dated January 15, 2022 a 12:03 p.m., indicated an unlicensed personnel and R1 argued about R1's personal TV being in the livingroom. "She was calling staff bitches and snitches." R1 and staff argued. R1 spit on staff and the police were called. The progress note did not specify who R1 spit at. The Incident and Emergency Report, dated January 17, 2022, completed by PM-D, included a section called "Required Notifications: completed within 24 hours of discovery or receipt of information that the incident occurred" with check boxes and spaces for dates and times. PM-D checked "legal representative" emailed on 1/17 at 11:15 a.m. "case manager" emailed on 1/17 at 11:15 a.m., "designated emergency contact" on 1/17 at 11:15 a.m.. The DHS Licensing Division, MN Office of the Ombudsman, Common Entry Point/Child Protection Agency sections were not checked. The "internal maltreatment report filed" section was also blank. The section called Designated Manager review and recommendation listed a	0 730		

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0 730	Continued From page 13 pattern of "accusing behaviors and manipulation" and "corrective action was needed. Will be discussed with team." R1's record lacked documentation a care team follow up was conducted after the incident. R1's record as lacked detail of the incident including the action of ULP-A throwing a computer mouse and hitting R1. During an interview on June 22, 2022 at 11:15 a.m., the owner and licensed assisted living director (LALD)-C said R1's care team had and probation officer had a meeting with her after the incident with ULP-A. LALD-C said there was no documentation of the meeting or any corrective action. LALD-C said the nurse was updating all service plans and assessments and R1's IAPP from November 30, 2020 was the only one in her record. During an interview on July 5, 2022 at 10:01 a.m., social worker (SW)-B said she and the parole officer meet weekly or bi-weekly with R1. SW-B said the licensee's biggest issue is communication and follow-up. During an interview on July 7, 2022 at 9:45 a.m., ULP-A said on January 13, 2022, she observed R1 playing a video game on the TV. ULP-A said R1 told her she had accessed Google through the video game. ULP-A said that was a violation of R1's probation and she took a photo of R1 on the internet and sent it to the program manager (PM)-D. The next day, January 14, 2022, ULP-A went to work and said R1 was upset because her parole officer had been notified of the probation violation. ULP-A said R1 threatened her most of the shift and ULP-A tried to get R1 to calm down and stop threatening her but R1 escalated. She	0 730		

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0 730	Continued From page 14 asked to speak to PM-D but ULP-A called LALD-C by accident. R1 spit in ULP-A's face and called her names. ULP-A said she just grabbed the computer mouse and threw it at R1 but did not aim at her head, she just wanted R1 to back away from her. ULP-A said ULP-E was downstairs with another resident during the incident so there were no witnesses. ULP-A said LALD-C told her to go home and ULP-E would write a progress note on the incident. ULP-A said she and R1 both cried and apologized. During an interview on July 7, 2022 at 1:01 p.m., LALD-C stated R1's case worker and parole officer are updated by email weekly. LALD-C was not sure the emails were part of R1's record and would have to check. A policy titled Resident Record Documentation, dated August 1, 2021, read: Staff of Midwest Homes, Inc. authorized to document in a resident record will do so for all medications, services, treatments and therapies for each resident. Staff will also document all other important and pertinent information relating to each resident; new problems, resident or family concerns, a change of condition, incidents, family problems. TIME PERIOD TO CORRECT: Seven (7) Days	0 730		
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:	02360		

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02360	Continued From page 15 Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On August 2, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was 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.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report (sent separately) for details.	
03000 SS=D	626.557 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, 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	03000		

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03000	Continued From page 16 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, 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 and record review, the licensee failed to comply with requirements for immediately reporting an incident of maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one residents (R1) reviewed. Unlicensed personnel (ULP)-A threw a computer mouse and hit R1 on the head after R1 spit at ULP-A during an argument. This practice resulted in a level two violation (a violation that did not harm a client's health or	03000	No further action required.	

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03000	Continued From page 17 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). Findings include: R1's diagnoses included fetal alcohol disorder, attention deficit disorder, intermittent explosive disorder, oppositional defiant disorder and anxiety. R1's service plan, dated November 30, 2020, indicated R1 received supervision and cueing for bathing, grooming and oral cares. R1's medication assessment and management plan, dated November 30, 2020 assessed R1 as unable to safely administer medications at the scheduled times correctly and consistently and would receive medication administration from licensee staff. R1's behavior plan, dated November 30, 2020, instructed staff to talk with R1 privately if she displayed verbal or physical aggression. If R1 threatens self or others, separate R1 and attempt to talk with her about the situation. If there is imminent danger to self or others staff will call police or 911, in all cases in which the program manager, administrator, owner or police are called, an incident report must be completed prior to end of shift. The January 9 through January 15, 2022 staff schedule, listed the January 14, 2022 evening caregiver (4 p.m. to 12 a.m.) as ULP-A. A second staff member listed on the schedule for that shift did not work. ULP-E worked the 4 p.m. to 12 a.m. shift instead.	03000		

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03000	Continued From page 18 A law enforcement report dated 1/14/2022, indicated: At 18:03:59 an incident was called for an assault in progress. At 18:04:00 just occurred, [client] lives at group home, was hit by staff member. At 18:07:34 staff member calling in states resident spit in her face waiting across street. At 18:18:58 staff is aok with resident tings {sic} being resolved. A progress note, dated January 15, 2022 a 12:03 p.m., indicated a ULP and R1 argued about R1's personal TV being in the livingroom. "She was calling staff bitches and snitches." R1 and staff argued. R1 spit on staff and the police were called. The progress note did not specify who R1 spit at. ULP-E wrote the progress note. The Incident and Emergency Report, dated January 17, 2022, completed by program manager (PM)-D, included a section called "Required Notifications: completed within 24 hours of discovery or receipt of information that the incident occurred" with check boxes and spaces for dates and times. PM-D checked "legal representative" emailed on 1/17 at 11:15 a.m. "case manager" emailed on 1/17 at 11:15 a.m., "designated emergency contact" on 1/17 at 11:15 a.m. The DHS Licensing Division, MN Office of the Ombudsman, Common Entry Point/Child Protection Agency sections were not checked. The "internal maltreatment report filed" section was also blank. The section titled "Designated Manager review and recommendation" listed a pattern of "accusing behaviors and manipulation" and corrective active action was needed. "Will be discussed with team."	03000		

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03000	Continued From page 19 During an interview on June 22, 2022, at approximately 10:15 a.m., R1 said ULP-A got mad at her for wanting to call PM-D and yelled at R1 and threatened to call the police and have her jailed. During an interview on June 22, 2022 at 11:15 a.m., the owner and licensed assisted living director (LALD)-C said R1 should not be on social media because of a court order and when ULP-A asked R1 what she was doing on a computer, R1 spit at ULP-A and ULP-A threw the computer mouse at R1. LALD-C said ULP-A "was talked to" about the incident, but was not suspended and there was no staff retraining. There was no documentation in her employment file aboout the incident. LALD-C said she met with R1's care team and probation officer about the incident but there was no documentation of that meeting. LALD-C said she did not file a MAARC report because PM-D called SW-B and reported the incident to her. During an interview on July 5, 2022 at 10:01 a.m., social worker (SW)-B said R1 can be tough and did spit on staff which is not ok. SW-B said staff are trained on what to do and can't just throw a computer mouse at someone. SW-B said licensee staff did write an internal incident report but they did not file a MAARC report which they should have done. SW-B said she asked LALD-C why ULP-A continued to work at the house after she hit R1 in the head and suggested that ULP-A should not continue to work there. LALD-C told her it was a reflexive reaction by ULP-A to throw the computer mouse. During an interview on July 6, 2022 at 11:02 a.m., R1 said ULP-A threw the computer mouse at the left side of the head and she had a painful bump	03000		

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03000	Continued From page 20 for a week. R1 said her grandmother was on the phone with her at the time and heard staff yelling at R1. R1 stated ULP-A is a good person and someone she likes, but she went "ape shit" that night. During an interview on July 6, 2022 at 2:31 p.m., program manager (PM)-D said the incident happened in the evening on January 14, 2022. R1 had a court order prohibiting her from using social media and she'd figured out a way to log onto the Internet through a video game. Staff were monitoring her device use, which made R1 angry and it escalated. PM-D stated she had finished her shift at the house and was home about 30 minutes when she go calls from ULP-A and LALD-C about R1's behaviors. PM-D completed an incident report and called R1's parole officer and SW-B on January 17, 2022. PM-D said she was not trained on MAARC reports and never filed a MAARC report for any incidents, that was up to LALD-C or a case worker. During an interview on July 7, 2022 at 9:45 a.m., ULP-A said on January 13, 2022, she observed R1 playing a video game on the TV. ULP-A said R1 told her she had accessed Google through the video game. ULP-A said that was a violation of R1's probation and she took a photo of R1 on the internet and sent it to the program manager (PM)-D. The next day, January 14, 2022, ULP-A went to work and said R1 was upset because her parole officer had been notified of the probatin violation. ULP-A said R1 threatened her most of the shift and ULP-A tried to get R1 to calm down and stop threatening her but R1 escalated. She asked to speak to PM-D but ULP-A called LALD-C by accident. R1 spit in ULP-A's face and called her names. ULP-A said she just grabbed	03000		

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03000	Continued From page 21 the computer mouse and threw it at R1 but did not aim at her head, she just wanted R1 to back away from her. ULP-A said ULP-E was downstairs with another resident during the incident so there were no witnesses. ULP-A said LALD-C told her to go home and ULP-E would write a progress note on the incident. ULP-A said she and R1 both cried and apologized. A policy titled Vulnerable Adult Maltreatment - Prevention and Reporting, dated August 1, 2021 indicated Midwest Homes prohibits the maltreatment of residents. Midwest Homes educates clients, family members and staff (mandated reporters) about reporting suspected maltreatment internally and the the Minnesota Adult Abuse Reporting Center (MAARC). Staff who suspect maltreatment of a resident or who sustained a physical injury not reasonably explained, will contact the Clinical Nurse Supervisor and the Assisted Living Director. If they confirm suspicion on maltreatment they will contact MAARC and such a report must be made no later than 24 hours after the maltreatment was first suspected. Time Period to Correct: SEVEN (7) DAYS	03000		