Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356988103M
Compliance #: HL356984381C

Date Concluded: March 20, 2025

Name, Address, and County of Licensee Investigated:
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), who was performing maintenance work at the facility, physically abused the resident when he held the resident around his waist and shoulders during a physical altercation between the resident and another facility resident and facility staff.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP held the residents' arms across his waist from behind to prevent the resident from continuing a physical attack on another facility resident and staff member. The AP released hold of the resident once the other resident and staff were in a safe location away from the resident. The resident proceeded to punch the windows of the facility before law enforcement arrived.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted law enforcement and a family member. The investigation included review of the resident records, hospital records, facility internal

investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. While on site, the investigator observed resident and staff interactions, and resident to resident interactions.

The resident resided in an assisted living facility. The resident admitted to the facility with a known history of physical aggression and property destruction at a previous living facility. The resident's diagnoses included autism spectrum disorder and schizoaffective disorder. The resident's service plan included assistance with medication administration and behavior management. The resident's assessment indicated the resident walked independently and was alert and oriented.

A facility incident report indicated the resident was sitting on the couch in the living room when another facility resident, who was confused, made a delusion statement to the resident while pointing her finger in his face. The resident responded by pulling her to the floor. As staff were assisting the resident on the floor, the resident became verbally aggressive and attempted to physically attack the other resident. When staff asked him to back away from the resident on the floor, he attempted to punch staff, which landed against the wall, causing the resident further rage. The report indicated the AP attempted to stop the resident from further attacking anyone, and the resident attempted to bite the AP. The resident went outside and punched the windows of the facility.

The resident's progress notes indicated the resident was outside punching facility windows when law enforcement arrived. Law enforcement transported the resident to the hospital.

A law enforcement report indicated the resident stated to law enforcement that he had an argument with another resident, then blacked out and did not remember what happened.

Hospital records indicated the resident reported he had been put in a choke hold and punched in the nose by a maintenance worker. The record indicated the resident reported his foot hurt from kicking a door, and nose pain. The report indicated the resident stated he was defending himself from another resident but could not fully remember the incident. The report indicated there was no septal hematoma and the resident was able to breathe clearly. The report indicated x-ray of the resident's foot were negative for injury. The report indicated CT (computed topography) imaging of the resident's face was unremarkable except for a small nasal bone fracture. The report indicated the resident was discharged back to the facility in stable condition.

During an interview, the AP stated he entered the facility to see a female resident telling an unlicensed personnel (ULP)-1 the resident had punched her in the face. The AP stated the resident was upset and charged at ULP-1 who was attempting to calm the female resident down. The AP stated he told the resident to calm down, while ULP-1 was on the phone with 911. The AP stated he saw the resident push the female resident who was close to a stairwell and she had to hold on to the doorframe to prevent herself from falling down the stairs. The AP

stated when the resident pushed the female resident, he held the resident back by placing his right hand on the resident's right side, and his left hand on the resident's left side, while standing behind the resident. The AP stated he felt the female resident and ULP-1 were in imminent danger, and he was afraid the much larger male resident would hurt them if he did not do something. The AP stated the resident apologized to him for being out of control and thanked him for stepping in, because it would have turned out bad if he had not.

During an interview, ULP-1 stated when the resident was escalated, she attempts verbal de-escalation, re-direction and distraction to calm him down. ULP-1 stated she had to place herself between the resident and another resident in the past and was injured, so she no longer does that for her own safety. ULP-1 stated she calls 911 if the resident is out of control. ULP-1 stated while a female resident was telling her the resident punched her, the resident came running towards them and pushed the female resident. ULP-1 stated she screamed at the AP to help her. ULP-1 stated the AP held the resident's arms down in a crisscross manner while standing behind the resident, and the resident bit the AP's hand. ULP-1 stated when the AP let go, the resident ran outside and began punching the windows of the facility. ULP-1 one stated the AP only held the resident's arms down, nothing more. ULP-1 stated the resident was always apologetic after physical altercations.

During an interview, the licensed assisted living director (LALD) stated the resident had been visiting as a guest to the facility for two years before he admitted as a resident. The LALD stated they began to see physical and verbal aggression from the resident two months after admission. The LALD stated the aggressions had been spontaneous and unprovoked. The LALD stated he was concerned the resident makes false allegations towards staff to appear as a victim and delay an eviction notice process the facility has started due to all his physical attacks on staff and residents. The LALD stated the resident has remained very apologetic and promised to do better, so they allowed for him to remain at the facility.

During an interview, the resident stated the staff treat him well, with dignity and respect. The resident stated the AP stepped in to protect ULP-1, by dragging him to the floor. The resident stated he could not remember the incident too well, as he was trying to block it out. The resident stated he usually gets upset for stupid reasons. The resident stated the AP should not have put his hands on him.

During an interview, a family member stated the resident does not always state facts accurately. The family member stated the resident has a life history of verbal and physical aggression when he gets upset and acts out instead of thinking about his choices. The family member stated the resident reacts in a fight or flight response. The family member stated she felt the resident was safe at the facility and did not know of or have any concerns about the care and treatment of the resident at the facility. The family member stated she would expect staff to defend themselves and others however they needed to if the resident was attacking them.

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;
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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility staff provided de-escalation attempts, protected the second resident and called 911.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 On February 28, 2025, the Minnesota Department of Health initiated an investigation of complaint HL356984381C/HL356988103M and HL356984401C/HL356988122M. No correction orders are issued.	0 000		