Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356988122M
Compliance #: HL356984401C

Date Concluded: March 26, 2025

Name, Address, and County of Licensee Investigated:
Graceful Lodge
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) physically abused the resident when he choked the resident during an argument.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP was physically attacked by the resident who lifted and slammed him on to a dining room table. The resident landed on top of the AP and continued to attempt to punch the AP's face. The AP used his arms to try to hold the resident away from him and push him off him to protect himself.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted 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 reports, and related facility policy and

procedures. While on site, the investigator observed interactions between the resident and staff, and interactions between the resident and other facility residents.

The resident resided in an assisted 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 seated at the dining room table with the AP and another female resident. The female resident made a delusional statement and pointed her finger near the resident's face. The resident responded by standing up and hitting her over the head. The AP asked the resident to not do that again, and the resident moved closer to her as if he was going to hit her again. An unlicensed personnel (ULP) told the resident to stop. The resident threw the metal coffee cup he held at the AP and charged toward the AP with physical punches. The resident picked up a chair from the dining room table and hit the AP with it twice. He continued to swing his fists at the AP, landing two punches. The resident then tackled the AP on to the dining room table, landing on top of the AP. When the ULP tried to step in to help the AP, the resident swung at the ULP, who retreated to call 911. The AP sustained a skin tear to his arm, and a sprained right ankle. The report indicated the resident broke the dining room table, two chairs and the ice container in the refrigerator before he also called 911 and requested to be taken to the hospital to calm down. The resident returned to the facility after evaluation in the emergency department.

A law enforcement report indicated the resident had become physical with staff and broke a table and some chairs. The report indicated the resident requested to be put on a psychiatric hold.

Hospital records from the day after the incident indicated the resident presented to the emergency room again for back and knee pain related to the incident from the day before. The resident reported to hospital staff he was pushed onto a dining room table and choked by a staff member. The note indicated the provider reviewed the previous emergency room notes, which indicated a CT angiogram of the neck had been performed and was negative for acute findings. During this visit, the notes indicated the resident had full range of motion to the right knee. X-rays were obtained of the right knee and did not show any evidence of fracture or dislocation. The notes indicated there was no external signs of trauma noted. Due to having no midline tenderness to the spine, and a normal neurological exam in all extremities, no further imaging or testing was completed on the resident's back. The notes indicated the emergency room provider felt the resident was safe to discharge back to the facility.

During an interview, the AP stated neither he nor other staff have received any training on physical holds or defense. The AP stated verbal de-escalation was always attempted and used when a resident is escalated and was mostly successful to calm residents. The AP stated the resident had multiple physical altercations since residing at the facility, and the facility had

started the eviction process at one point because of the physical altercations. The AP stated the resident's outbursts were spontaneous and were sometimes triggered when other residents were not doing what he thinks they should be, or not following staff direction. On the night of the incident, the AP stated he and the resident were chatting at the dining room table about the resident's interest in computers when another female resident made a delusional comment to the resident. The resident hit the female resident over the head. The AP stated he told the resident to stop that, which upset the resident further and he threw a metal coffee cup at him. The resident became further upset when the coffee cup missed the AP, so he picked up a chair and began to hit the AP with it. The AP stated he was able to hold that chair away to prevent it from hitting him further, so the resident grabbed another chair and came towards the AP. The AP stated he was able to remove that chair from the resident's hands, and that was when the resident picked him up, slammed him on the dining room table and landed on top of him. The AP stated he was using his hands to push the resident away from him so he could breathe as the resident was much larger and heavier than him. The AP stated he was able to push the resident off him, and he got up. The AP stated that was the end of the physical altercation. The AP denied ever placing his hands on the resident's neck. The AP stated if there were red marks on the resident's neck, it could have maybe been from the resident's shirt being pulled tight on the resident's neck when he was attempting to push the resident off him. The AP stated the resident was very apologetic after the incident.

During an interview, the ULP stated the resident gets angry at other residents and sometimes punches the walls. The ULP stated the AP treats the residents at the facility very nice and was calm with them. The ULP stated on the night of the incident, she had left the dining room to go get a bag, when she heard a loud noise. The ULP stated she ran back to the dining room and witnessed the AP on the table with the resident on top of him, hitting the AP. The ULP stated she removed the nearby female resident and begged the resident to stop hitting the AP. The ULP stated the resident got up and walked away. The ULP stated she never witnessed the AP choke or place his hands on the neck of the resident. The ULP stated she only witnessed the AP holding the resident away from him while on the table and blocking his face as the resident attempted to punch the AP's face. The ULP stated the resident was not a reliable reporter, and often tells untrue stories. The ULP stated the resident often apologizes to staff after physical altercations.

During an interview, the resident stated the staff treat him well and with dignity and respect. The resident stated he got mad at the AP and pushed him into a wall. The resident said the AP then choked him, and he went to the hospital where they noted red marks on his neck. The resident stated the AP choked him for four to five minutes. The resident stated he may have called 911 after the incident but could not remember. The resident denied any other physical incidents with staff.

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;
(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 provided protection towards the other resident, attempted de-escalation, and the resident went to the hospital for evaluation.

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		