Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36174001M
Compliance #: HL36174002C

Date Concluded: October 25, 2022

Name, Address, and County of Licensee Investigated:
Step Forward, Inc.
3448 20th Avenue South
Minneapolis, MN 55407
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Shannan Stoltz, 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 unlicensed personnel (ULP)/alleged perpetrator (AP) neglected the resident when the AP transported the resident to a community meeting, allowed the resident to attend the meeting unsupervised and the resident eloped.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to provide 1:1 direct supervision of the resident as detailed in the resident's service plan. The resident eloped and his whereabouts were unknown for approximately five days.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident, as well as staff at a state

security hospital. The investigation included an onsite visit for observations, review of medical records, and review of facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included borderline personality disorder and alcohol use disorder. The resident's service plan directed staff to provide 1:1 direct observation and supervision at all times. The resident's assessment indicated the resident had impaired decision-making skills, but was orientated to person, place, and time. The resident's medical chart indicated the resident moved to the facility on a conditional release from a state security hospital.

A facility incident report, completed by the AP, indicated the resident was left unattended at a community meeting while she (AP) left the premises to purchase food. The report indicated when the AP returned to the meeting, the resident had eloped. The resident was missing for approximately five days before law enforcement located and returned him to the state security hospital, where his conditional release was revoked.

During an interview, an administrative staff member stated all new staff, including the AP, completed 40-hours of computer training and skills training provided by the facility nurse. Staff also received mental health training, which included specifications of provision of 1:1 direct observation and supervision of residents. The administrative staff member stated new staff also meet with the facility's program manager to acknowledge and reiterate the received training, and every staff member is oriented to the specific needs of the residents in the facility.

During an interview, the nurse confirmed she provided training to all staff regarding mental health diagnoses/challenges, and the criteria/importance involved with providing 1:1 direct observation and supervision of a resident. The nurse confirmed the AP received this training.

During an interview with the program manager, he stated the resident's needs were discussed and reviewed with the AP approximately one week prior to the incident. The manager confirmed he reviewed the requirement of 1:1 direct observation and supervision of the resident. The manager stated he made it clear that 1:1 observation and supervision included attending meetings with the resident. The manager indicated following the training review session, the AP verbalized understanding of the criteria and importance of 1:1 direct observation and supervision which included to never take eyes off the resident. The manager stated that during completion of the internal investigation into this incident, the AP verbalized she had left the resident unattended at the meeting, while she drove to get something to eat. The AP acknowledged with the manager that her actions did not correspond with the training she received from the facility regarding 1:1 observation and supervision of residents.

During interviews, multiple staff members confirmed they were trained on the provision of 1:1 observation and supervision, which included the criteria and importance of always maintaining constant visual contact of a resident.

During an interview, the resident acknowledged the AP was a new employee and stated the AP dropped him off at his meeting unattended while she went to get something to eat. The resident stated he left the meeting, went to a friend's house for a night, then went to a family member's home. The resident

indicated approximately four or five days later he was found by law enforcement and returned to the state security hospital.

During an interview, the AP acknowledged she transported the resident to a community meeting. The AP allowed the resident to enter the building and attend the meeting alone, then left the premises in her vehicle to get something to eat. The AP returned to the meeting site approximately 15 minutes later and sat in the vehicle in the parking lot awaiting the resident's return. When the resident did not return, the AP went inside the building to the meeting location but was unable to find the resident. The AP stated she searched the area, then called the program manager to report the resident missing. The AP stated she also contacted law enforcement and completed a missing person report. The AP stated the program manager trained her on the criteria of providing 1:1 direct observation and supervision, which included to always maintain visual contact of a resident. The AP stated she was also trained to attend meetings with the resident, and the manager had "made that pretty clear". The AP stated she did not completely comprehend the importance or full responsibility of a 1:1 observation, as this was her first job as an unlicensed caretaker. The AP stated she has now realized the gravity of the situation, that it should not have happened, and regrets her decision to get food and not accompany the resident into the meeting.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility disciplined and re-educated the AP. In addition, all staff were provided further training on 1:1 supervision and observation.

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
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
	36174	A. BUILDING: _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEP FORWARD INC	158 71ST WAY NE FRIDLEY, MN 55432

(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 INITIAL COMMENTS: HL36174002C/HL36174001M On September 29, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. The following correction order is issued for HL36174002C/HL36174001M, tag identification 2360.	0 000		
02360 SS=D	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: Based on observations, interviews, and document review, the facility failed to ensure one of three residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person was responsible for the maltreatment, in connection with an incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	