Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36907001M
Compliance #: HL36907002C

Date Concluded: March 1, 2022

Name, Address, and County of Licensee Investigated:
Ottawa Home Health Services
3554 Boone Avenue North
New Hope, MN 55427
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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.

Allegation(s): The alleged perpetrator (AP), a staff member, abused a resident when they pushed a resident down on the floor and restrained the resident with a broom.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrator was responsible for the maltreatment. The resident and a witness said the AP pushed the resident down. The AP admitted during the facility's investigation she pushed the resident to the floor, but stated she pushed the resident in self-defense.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The facility was toured, and observations were made of staff and resident interactions. The residents' medical records, employee personnel records, facility policies and procedures related to admissions, staff training, complaints, contracted staff, emergency procedures, employee records, assisted living rules, service plans, staff orientation,

staffing plan, and prevention of maltreatment to vulnerable adults were reviewed. Law enforcement was contacted, and the police report was reviewed.

The resident (R1) lived at the facility for almost one year, due to diagnoses including chronic obstructive pulmonary disorder (COPD), obesity, generalized muscle weakness, renal failure, type 2 diabetes, difficulty walking, respiratory failure, generalized anxiety disorder, bilateral hearing loss, chronic pain, depression, and post-traumatic stress disorder. The resident received services including assistance with ambulation/exercise, bathing assistance, escort/mobility assistance, socialization, housekeeping, laundry, management of agitation, management of anxiety, meal assistance, medication administration, shopping assistance, and skin care. R1's abuse prevention plan directed staff to remove other residents, speak calmly to the resident, and ask R1 to go to his room until he is calm when the resident was verbally aggressive.

The incident report indicated the AP pushed R1 to the floor and attempted to hold R1 down on the floor with a broom.

The facility investigation indicated the AP contacted the chief operations officer (COO) on the day of the incident to report R1 had hit the AP with a broom and the AP called the police. The investigation indicated the AP stated she pushed the resident to the ground. When R1 was interviewed about the incident he stated the AP got in R1's face and then pushed R1 to the ground and held him down with a broom.

During an interview, the COO stated the AP told him she pushed R1 down, R1 told him that the AP pushed him down, and another resident witnessed the AP pushing R1 down. The COO stated R1's medical record provided a number of interventions for staff to use if R1 was agitated such as engage in activity, give short simple instructions, verbally redirect, assist to another location, and change staff.

During an interview, a resident (R2) who witnessed the incident stated the AP told R1 not to touch the window shades, but R1 touched them. R2 stated the AP got in R1's face and R1 and the AP were yelling at each other. The AP grabbed R1 by the shoulders and threw him onto the floor. R1 then grabbed something and hit the AP and then the AP held R1 on the floor.

During an interview, a nurse stated staff were required to review each resident's abuse prevention plan that popped up on their computer screen when they sign on and stayed on the screen until they reviewed it. The nurse provided training to the AP about the basics of abuse prevention. The nurse stated R1's symptoms of post-traumatic stress disorder flared up after the incident, when he had difficulty sleeping and had increased anxiety.

During an interview a family member stated R1 had a brain injury from a car accident several years ago and had agitation, anxiety, and verbal aggression, such as calling people names. The family member stated R1 used a walker and a cane. R1 had surgery on his elbow a month prior

to the incident, and his elbow was very swollen after the incident. The family member stated R1 changed emotionally after the incident and showing more stress, had difficulty sleeping, and fearfulness.

During an interview, R1 stated on the morning of the incident, he went to the window to open the blinds and the AP said something R1 could not hear. R1 said the AP moved closer to him, said something again, and R1 turned his good ear toward the AP, but still could not hear her. R1 said he did not know what got the AP so upset but she hit him with both hands, palms forward, on his chest, which caused R1 to fall onto the floor. R1 stated he hit his elbow he just had surgery on. The AP held R1 on the ground with the brush end of a broom and told him to stay down. R1 stated he pulled himself onto the couch to get up and called the AP lots of names, grabbed the broom, and hit the AP with it. R1 stated the AP called the police and R1 went to the emergency room and came home the same day. R1 stated he had trouble sleeping because of the incident.

During interview, the AP stated the facility did not provide staff with information about the resident's behaviors, triggers, or backgrounds. The AP did not recall signing off on a pre-hire document that described the behaviors of the types of residents that lived at the facility (such as being difficult, demanding, verbally aggressive, name calling [using the N word, B word, and C word], threatening to call the state), or that it contained interventions to use. The AP stated R1 was physically aggressive, and she did not expect that behavior. The AP stated R1 called her racist, sexual names, ran up to her, spit on her, and hit her with a steel broom. The AP stated she protected herself and R1 fell. The AP stated she called 911, the COO, and the nurse. The AP stated she did not receive training on handling resident behaviors and did not have access to the residents' service plans.

In conclusion abuse was substantiated. The AP is responsible for the abuse.

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.

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

Action taken by facility:
The AP is no longer employed by the facility.

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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
New Hope Police Department
Hennepin County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36907	A. BUILDING: _____ B. WING _____	C 02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OTTAWA HOME HEALTH SERVICES	**3554 BOONE AVENUE NORTH NEW HOPE, MN 55427**

(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: #HL36907002C/#HL36907001M On February 23, 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 3 clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL36907002C/#HL36907001M, tag identification 0620, and 2360.	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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	
0 620 SS=F	144G.42 Subd. 6 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 document review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one resident (R1) reviewed for maltreatment. R1 reported a staff unlicensed personnel (ULP)-D pushed R1 onto the floor, hit him with a broom, and restrained him on the floor with a broom. The nurse who was informed on the day of the incident did not file a report and the chief operating officer filed a report two days after the incident. The failure to implement the facility policy on reporting suspected maltreatment had the potential to affect all 3 residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 620		

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0 620	Continued From page 2 R1 was admitted to the assisted living facility on April 5, 2021, due to diagnoses including chronic obstructive pulmonary disorder (COPD), obesity, dysphagia, generalized muscle weakness, renal failure, type 2 diabetes, difficulty walking, respiratory failure, generalized anxiety disorder, bilateral hearing loss, and chronic pain. R1's service plan dated July 28, 2021, indicated R1 received services from the licensee that included ambulation/exercise, bathing assistance, escort/mobility assistance, group socialization, housekeeping, laundry, management of agitation, management of anxiety, management of orientation, meal assistance, medication administration, one on one socialization, documentation of vital signs (blood glucose, blood pressure, pulse, and weight), shopping assistance, and skin care. A undated document identified as Incident Interviews indicated unlicensed personnel (ULP)-E contacted chief operating officer (COO)-F on December 4, 2021, to report R1 had hit ULP-E with a broom and ULP-E called the police. The document indicated ULP-E told COO-F she pushed R1 to the ground. The document indicated on December 5, 2021, COO-F spoke with R1,who stated ULP-E got in R1's face and then pushed R1 to the ground and held him down with a broom. During an interview on February 24, 2022, at 12:45 p.m. registered nurse (RN)-D stated ULP-E called her about the incident on the day it happened before the police arrived. RN-D stated later that day she called R1, who told her ULP-E was the aggressor. RN-D did not report the alleged maltreatment to MAARC.	0 620		

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0 620	Continued From page 3 During an interview on February 28, 2022, at 10:14 a.m. COO-F stated the facility procedure for filing a MAARC report included gathering information, interviewing anyone with information, then calling the report in to MAARC. COO-F stated RN-D received training on reporting allegations of maltreatment and was a mandated reporter. COO-F filed a MAARC report two days after the incident. The Vulnerable Adult Maltreatment- Prevention and Reporting policy dated August 1, 2021, indicated all staff were trained on the identification of incidents of maltreatment and were mandated reporters. If the assisted living director or clinical nurse supervisor confirmed the suspicion of maltreatment, they would then contact the Minnesota Adult Abuse Reporting Center no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		
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: Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include:	02360		

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02360	Continued From page 4 On February 23, 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		