Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL37104001M
Compliance #: HL37104002C

Date Concluded: March 22, 2022

Name, Address, and County of Licensee Investigated:
Greater Care Facilities
2087 Woodbridge Way
Woodbury, MN 55125
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility 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) restrained the resident on more than one occasion, placed a knee on the resident's neck, and grabbed the resident's breasts during a restraint.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility was responsible for the maltreatment. Staff acknowledged they held the resident's arms to prevent her from self-harm during an incident, and a police officer witnessed a staff restrain the resident's legs during another incident. The licensee failed to provide staff with interventions to use when the resident became agitated. The investigation found no evidence to indicate staff placed a knee on the resident's neck or grabbed the resident's breast.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility and observed staff/resident interactions. The investigator reviewed resident records, hospital records, police

reports, facility documents, incident reports, policies, and procedures related to code of conduct, incident reports, restraints, and maltreatment of vulnerable adults.

The resident lived in the facility for about two months and received services from the assisted living provider that included behavior documentation, grooming assistance, housekeeping, meal assistance, medication administration, safety checks, and wound care. The resident had a history of self-injury and received 24 hour one to one female only staffing.

According to a progress note the resident packed a bag one day and attempted to elope from the facility so the staff stood in front of the doors to block the resident from leaving. The progress note indicated the resident tried to hit staff, so the staff held the resident down on the floor for an unknown amount of time. The resident banged her head on the floor, so the staff let her up. The staff called 911 and the ambulance took the resident to the hospital.

Incident reports indicated the resident had more than 10 instances of self-harm and/or elopement with police intervention after the initial incident.

According to an incident report note, the resident expressed suicidal thoughts one day. The resident went into the bathroom and attempted to break a lightbulb to cut herself. The note indicated the resident then ran down to the laundry room and staff prevented the resident from grabbing a bleach container. The resident became upset, grabbed staff clothing, and punched staff. The note indicated the resident grabbed staff hair and broke staff glasses, saying she would swallow the glass. The note indicated the resident fell to the floor and staff did not let the resident get up until the police came.

During an interview, a staff involved in the incident stated that the resident fell to the ground on the stairs during the incident and two staff held the resident on the ground by her hand and legs.

During an interview, a responding police officer stated he observed one staff straddle the resident's legs to prevent the resident from kicking. The officer stated the other staff held the resident's arm trying to retrieve a pair of staff glasses the resident held.

During interviews, two unlicensed personnel stated that during the first incident they held the resident's arms to prevent her from throwing and breaking things. Both indicated they did not feel it was a restraint because they let the resident go.

During an interview, the nurse stated the staff restrained the resident to prevent harm to others. The nurse stated the staff received verbal information about interventions to try with the resident when behaviors escalated.

During an interview, the case manager stated the resident remained hospitalized at the time of the investigation approximately 30 days after the second incident.

In conclusion, abuse is 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:
(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.
(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; and

Vulnerable Adult interviewed: Unable to interview, in the hospital.
Family/Responsible Party interviewed: No, the guardian did not respond to interview requests.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility changed their admission procedure to include a deeper review of potential residents' histories prior to making an admission decision.

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
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY WOODBURY, MN 55125

(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: #HL37104002C/#HL37104001M On March 17, 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 2 clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL37104002C/#HL37104001M, tag identification 0630 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.	
0 630 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 document review, the licensee failed to update the individual abuse prevention plan (IAPP) for one of one resident (R1) reviewed when R1 had multiple incidents of self-injury requiring hospitalization. The licensee failed to update R1's IAPP to reflect the incidents and failed to include specific measures for staff to take to minimize the risk to R1. Harm occurred when R1 cut herself multiple times, bit out a section of flesh from her breast, and experienced trauma when restrained by staff during two of the incidents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include:	0 630		

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0 630	Continued From page 2 R1 moved into the facility on December 2, 2021, due to diagnoses that included anxiety, attention deficit hyperactivity (ADHD), depression, autism spectrum disorder, mood disorder, and impulsivity. R1's hospital records dated January 1, 2022, and February 20, 2022, included diagnoses of disruptive mood dysregulation disorder and borderline personality disorder. R1's service plan dated December 2, 2021, indicated R1 received services from the licensee that included behavior documentation, grooming assistance, housekeeping, meal assistance, medication administration, safety checks, and wound care. R1's nursing assessment dated December 3, 2021, safety section (page 4) indicated R1 had a risk of elopement, was at risk of self-abuse and the licensee provided 24 hour one to one staffing. R1's nursing assessment dated December 17, 2021, safety section (page 4) indicated R1 had a risk of elopement, was at risk of self-abuse and the licensee provided 24 hour one to one staffing. R1's incident report dated December 21, 2021, indicated staff observed R1 was agitated and had cut herself with a broken lightbulb. The staff called 911 and an ambulance took R1 to the hospital. R1's incident report dated December 22, 2021, indicated R1 attempted to elope, staff "held [R1] down", R1 banged her head on the floor, staff called 911, and an ambulance took R1 to the hospital. R1's incident report dated January 2, 2022,	0 630		

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0 630	Continued From page 3 indicated R1 told staff she wanted to go to the hospital because she felt like harming herself. The report indicated staff redirected R1, who then called the 911 herself. The report indicated R1 went to and returned from the hospital the same day, refused to get out of the van, eventually did, but walked away from the building when it was very cold. The report indicated staff called 911 for assistance from police to get R1 into the building. R1's nursing assessment dated January 17, 2022, safety section (page 4) indicated R1 had a risk of elopement, was at risk of self-abuse and the licensee provided 24 hour one to one staffing. R1's incident report dated January 19, 2022, indicated R1 locked herself in a closet and called police. The report indicated R1 told the police she would harm herself if they did not bring her to the hospital. An ambulance brought R1 to the hospital. R1's incident report dated January 23, 2022, indicated R1 went outside in cold weather without proper clothing, staff called 911 and police took R1 to the hospital. R1's incident report dated January 27, 2022, indicated R1 eloped from the building on a cold day when not allowed to use a laptop. The report indicated staff were advised (by licensed assisted living director (LALD)-B) to first call crisis and then call the police. Staff called crisis, but R1 had walked out of the building, so they called police, who took R1 to the hospital. R1's incident report dated January 31, 2022, indicated R1 expressed suicidal thoughts and staff called crisis but R1 refused to talk with crisis staff. The report indicated staff then called 911	0 630		

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0 630	Continued From page 4 and an ambulance took R1 to the hospital. R1's incident report dated February 2, 2022, indicated R1 tried to cut herself with a broken light bulb, bit a section of flesh from her breast, staff called 911, and an ambulance took R1 to the hospital. R1's incident report dated February 3, 2022, indicated R1 took a kitchen knife to cut herself, fought with staff, who called 911, and an ambulance took R1 to the hospital. R1's nursing assessment dated February 14, 2022, safety section (page 4) indicated R1 had a risk of elopement, was at risk of self-abuse and the licensee provided 24 hour one to one staffing. The assessment indicated R1 had a history of elopement and directed staff to call police for any elopement incident. R1's IAPP dated February 14, 2022, identified the following areas of vulnerability and interventions: R1 was at risk of elopement-plan of action: 24 hour one to one staff, staff to call police in elopement incident. R1 was at risk to abuse other vulnerable adults-plan of action: 24 hour one to one staffing and 12 hours of back-up staffing. R1 was at risk to abuse themselves-plan of action: "self-inflicted injuries". R1's incident report dated February 20, 2022, indicated R1 "ate her flesh and was bleeding" from a bite to her breast. The report indicated staff called 911 and an ambulance took R1 to the hospital. An attached report note dated February 20, 2022, indicated R1 broke a light bulb and cut herself, became aggressive with staff (hitting and punching), broke staff glasses, and staff called	0 630		

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0 630	Continued From page 5 911. The report note indicated staff held R1 on the floor in the hallway until police arrived. A police report dated February 21, 2022, indicated that during an incident the day before (February 20, 2022), the officer on scene "observed employees on top of [R1] when she had staff glasses". During an interview on March 17, 2022, at 3:32 p.m. licensed assisted living director (LALD)-B stated they were aware of R1's history of sexual assault and self-injury, so placed her on one-to-one female only staffing upon admission. LALD-B stated she did not think staff used restraint to control R1's behaviors, but upon review of progress notes, verified that staff had restrained R1. LALD-B stated they worked with a behavior support therapist but did not create a behavior support plan for R1. During an interview on March 18, 2022, at 8:50 a.m. case manager (CM)-E stated R1 remained hospitalized as of the date of the interview. During an interview on March 22, 2022, at 10:54 a.m. registered nurse (RN)-A stated that R1's incidents of self-injury and elopement attempts were not updated on the IAPP. RN-A stated he provided verbal education to unlicensed personnel about interventions for R1 but did not document the interventions or the education. The licensee's IAPP policy dated August 1, 2021, indicated the licensee would develop and implement an IAPP for each vulnerable adult that included statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. The policy indicated for the purposes of the IAPP, abuse	0 630		

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0 630	Continued From page 6 included self-abuse. The policy lacked content regarding updating the IAPP. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		
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 resident reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On March 17, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility 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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	