*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL3372228025M **Date Concluded:** November 13, 2023
**Compliance #:** HL372225084C

**Name, Address, and County of Licensee Investigated:**
Push Services Inc.
4757 Louisiana Avenue North
Crystal, MN 55423
Hennepin County

**Facility Type:** Assisted Living Facility (ALF) **Evaluator's Name:** Jennifer Segal RN, BSN
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 facility neglected a resident when the facility failed to provide one to one supervision leading to the resident cutting and strangling herself resulting in hospitalization.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The resident was in her private bathroom and cut her forearm, wrapped plastic around her neck and called 911. The resident was transported to the hospital. The facility staff had seen the resident 20 minutes prior and was providing supervision according to the residents individualized plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the residents case managers. The investigation included review of the resident's medical records, police reports, hospital records, county records, facility personnel records and facility policies

and procedures.  Also, the investigator observed care and interactions between staff and residents.

The resident's medical recorded indicated the resident resided in an assisted living facility and had diagnoses including bipolar and borderline personality disorder, depression, and fetal alcohol syndrome.  The residents record indicated the resident received one to one staff supervision for outings and appointments during the daytime. The resident's assessment and history indicated the resident was at greatest risk of self-harm when outside of the facility and therefore required constant staff supervision outside of the facility. The resident record did not indicate the resident required one to one, constant supervision while in the facility, in her bedroom, or in the bathroom.

A facility incident report indicated the resident obtained evening medication from staff and twenty minutes later a staff member heard an unexpected knock at the door.  The staff member opened the door and a police officer informed staff someone called from the facility to report they were hurt. The staff member was unaware of any calls or injuries and immediately directed the officer to the resident living area as other residents were within view and safe. The report indicated the resident was found in her room sitting on the bathroom floor with bleeding and injury to her arm. The report indicated when the officer asked the resident what was going on the resident requested to go to the hospital. The report indicated the resident was able to walk out of the facility and the ambulance transported the resident to the hospital.

The resident's hospital record indicated the resident tried to hang herself by wrapping something plastic around her neck, tied the plastic to the door and leaned forward. The resident provided pictures she took of herself during the attempt.  In addition, the record indicated the resident reported cutting herself on the forearm with a piece of glass.  The Hospital records indicated the resident reported feeling very frustrated about the facility and the staff, so the resident decided to hang herself on the bathroom doorknob. The resident reported she had chronic "suicidal thoughts every day," felt safe, and did better when she was in the hospital.

During interview an outside case manager stated the expectation was the facility would provide one to one supervision to the resident twelve to fourteen hours per day. The purpose of the one-to-one time was to provide transportation to appointments, attend social outings and be present when the resident wanted to get out in community. The case manager stated the resident had the right to privacy while in her private room and bathroom.  The case manager stated facility staff were available twenty-four hours per day in the facility for all residents and acknowledged the resident was scheduled for a separate staff member one-to-one time daily.

During interview multiple staff stated the resident required one on one staffing when out of the facility. However, if the resident was in her room or bathroom the staff were not required to provide constant supervision.

During interview the staff member assigned to the resident the day of incident stated when the resident left with the paramedic's staff went to the resident's bathroom and called the supervisor to report the incident. The staff noticed broken glass, a missing light bulb from the ceiling and found pieces of the glass bulb wrapped in a towel. The staff stated the resident was visually observed going into the bathroom to take a shower 20 minutes prior to the officer's arrival.

In conclusion, the Minnesota Department of Health determined neglect 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.

**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**: Not applicable
**Alleged Perpetrator interviewed**: Not applicable

**Action taken by facility:**
**None.**

**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 |
|---|---|---|---|
| | 37222 | A. BUILDING: _____ B. WING _____ | C 09/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PUSH SERVICES INC | 4757 LOUISIANA AVENUE NORTH CRYSTAL, MN 55428 |

| (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<br><br>On Septmeber 14, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL372228997C, #HL372225084C/ #HL372228025M. No correction orders are issued. | 0 000 | | |