Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HG2081402M
Compliance #: HG2081203C

Date Concluded: August 31, 2022

Name, Address, and County of Licensee Investigated:
Lake Owasso Residence
210 Owasso Boulevard North
Shoreview, MN 55126
Ramsey County

Facility Type: Intermediate Care Facility (ICF)

Evaluator's Name: Brandon Martfeld, RN
Special Investigator
Angela Vatalaro, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) physically abused the client, when she pushed the client around the house, causing the client to have aggressive behaviors.

Investigative Findings and Conclusion:
The Minnesota Department of Health (MDH) determined abuse was inconclusive. Written documents, facility interviews, and investigative interviews provided conflicting accounts of the alleged incident.

The investigator conducted interviews with facility staff members, including leadership staff, unlicensed staff, client's family member, and the AP. The investigation included review of the client's medical records, facility internal investigation notes, incident reports, the AP's

personnel file, and facility policies related to emergency use of a manual restraints, client behaviors, and maltreatment.

The client resided in an intermediate care facility. The client's diagnoses included autism, intellectual disability, and attention-deficit/hyperactivity disorder (ADHD). The client's assessments indicated the client required assistance with laundry, dressing, grooming, hygiene, toileting, bathing, and food preparation. The same assessment indicated the client's cognition level could not be assessed due to the inability to communicate verbally. The client's Abuse Prevention Plan indicated the client was at risk for physical abuse from others due to his cognitive inability to be aware of when a situation becomes abusive. The same Abuse Prevention Plan indicated the client was at risk for self-abuse due to self-injurious behaviors such as banging his head against hard objects and surfaces.

The facility's internal investigation indicated management interviewed multiple unlicensed personnel (ULP). The interviews consisted of the client coming into the house and wanted ULP-3's attention. The AP intervened between the client and ULP-3. The client became agitated as the AP pushed the client around the house. The ULP's reported the client became upset and started to hit his head on the table until it bled. The AP would not intervene or let the other ULP's intervene, stating to let the client continue to bang his head. The ULP's stated the AP pushed the client outside of the house. The AP put her foot in front of the door and prevented the client from entering the house while he was outside. Once the client returned inside the house, multiple ULP's reported the AP restrained the client on the couch, by his chest and neck. A text message from the AP to leadership indicated the client was agitated when his preferred staff member was assigned to a different client, and then another client attempted to take the client's food causing him to become upset.

During an interview, ULP-1 stated the AP intervened when the client wanted ULP-3 to work with him. However, ULP-3 was assigned to a different client. The client yelled and hit his head on the table. ULP-1 could not recall what the AP did while the client banged his head on the table. ULP-1 stated it was not unusual for the client to bang his head on the table when experiencing behaviors. ULP-1 stated the AP had her arms stretched out to prevent the client from hitting and reaching ULP-3. When inside the home, the client sat on the couch, the AP held the client by his shoulders, and told him to calm down.

During an interview, ULP-2 stated the client came home, seen ULP-3 working with a different client and became jealous. The client yelled and hit at the AP. The AP tried to calm the client. The AP told the client "Come on [client] let's go outside." Once back inside the home ULP-2 stated the client was "really mad." The client was in a seated position on the couch. The AP stood in front of him, client had his arms crossed in front of his chest, and the AP held his arms trying to keep him calm. ULP-2 stated later in the day she checked the client for bruises and no bruises were seen. ULP-2 stated she did not recall the client hitting his head on the table. ULP-2 stated the client's behaviors included hitting his head on the walls and table.

During an interview, ULP-3 stated the client became upset when he realized ULP-3 was assigned to a different client and wanted ULP-3's attention. The AP started to care for the client, but the client got upset and started to slap the AP. The client tried to hit ULP-3 and the other client. ULP-3 stated the client started to bang his head on the table. It was common during behavior episodes for the client to bang his head on the table and walls to the point that he would make himself bleed. The AP could not get close enough to client because he would try to headbutt and slap the AP. ULP-3 stated he told the client to stop banging his head on the table. The AP was able to get the client outside, by stating "[client] let's go outside." Once outside, the client slapped and scratched the AP. The client hit another staff member that tried to intervene while outside. The AP brought the client back into the home, and the client was "furious." ULP-3 rated the client's anger a 9 out of 10 once inside the home. Again, the client tried to hit ULP-3 and the other client. The client headbutted ULP-3 on his left side. ULP-3 stated the AP led the client to a couch in the living room. The AP tried to restrain the client's hands because the client "unleashed blows" to the AP. ULP-3 said after one hour, he went back out to the living room and the client was calm.

During an interview, ULP-4 stated while the AP and client were outside, she saw the client pull the AP's hair. ULP-4 went over to assist AP. When she got closer to the client and the AP, the client slapped ULP-4 on her face. ULP-4 stated the AP tried to grab the client's hands while he pulled the AP's hair.

During an interview, leadership staff-1 stated he was not at the house during the incident but returned to the house later in the shift. Leadership staff-1 stated the AP had scratches on her. Leadership staff-1 also stated he could not remember if the client had scratches or bruising.

During an interview, the AP stated the client became upset when another client attempted to grab the client's food at the dinner table. The client began to yell, circled the table, and struck out at her, ULP-3, and another client. The client sat at the table and hit his head against the table. While the client hit his head against the table, she never left the client's side, and continued to encourage the client to go outside. She attempted to get the client outside by saying "want to walk" or "let's eat outside." The AP stated she did not push the client outside. The client continued to hit, headbutt, and bite at the AP while outside. Another staff member came to assist while outside but used phrases that made the client angrier. While outside, the AP put her hand on the door to prevent the client from entering the home because she could see there were still other clients in the dining room. Once inside the home, she used her body to direct the client to the couch. The client continued to be aggressive, hitting, headbutting, and attempting to bite. The AP stated she used her hand at the client's sternum to keep the client from getting close enough to headbutt or bite her. The AP used a technique called emergency use of manual restraint, by holding the client's hands against his stomach area to prevent further hitting. The AP stated the client frequently hit his head against walls and tables. Once the client was on the couch, after several minutes, the client started to calm down.

During an interview, the client's family member stated they had no concerns with the incident between the client and the AP. The client's family member stated the client's ongoing behaviors included hitting, gouging skin, and would hit his head against walls and other hard surfaces. The client's family member stated going outside calmed the client.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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; and

Vulnerable Adult interviewed: No, unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Following the incident, the facility suspended the AP pending an internal investigation, investigated, educated staff, and updated the client's care plan.

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
	00831	A. BUILDING: _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE OWASSO RESIDENCE	210 OWASSO BLVD NORTH SHOREVIEW, MN 55126

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG2081402M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	5 000		