Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HG208188M **Date Concluded:** December 22, 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:** Christine Bluhm, 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 alleged perpetrator (AP) emotionally abused client when the AP yelled at the client and disconnected the client's phone preventing the client from making a phone call.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was substantiated. During an incident, the AP yelled at the client which made the client more upset. The AP continued yelling, would not allow the client to move about the facility and unplugged the phone cord preventing the client from making a phone call.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the case manager and guardian. The investigation included review of the facility internal investigation notes and client records.

The client's diagnoses included mild intellectual ability, schizoaffective disorder, and pervasive developmental disorder. The client's individual program plan included staff assistance with

medications, meal preparation and transportation and staff oversight and prompts with most activities of daily living. The client's assessment indicated the client could verbally make his needs known and received the standard level of staff supervision.

Review of the facility internal investigation records indicated the client's account of the incident matched the account given by witnesses which included the AP yelling, preventing the client from leaving his room, blocking the door, and unplugging the phone preventing the client from making a call. The client stated that he did not feel safe around certain staff which included the AP and, when the AP worked, she made him feel like he was in a prison. The records indicated the facility environment is one where the clients have the freedom to access common areas without restriction and interact with peers and staff freely.

During an interview, a staff member stated multiple staff members were in a meeting one morning to discuss house duties and client care plans. The staff member stated the client sat near them during the meeting. The staff member stated the AP stood up, yelled at the client, and told him to go to his room to which the client responded with behavior changes and anger. A short time later, the AP went to the client's room and saw the client making a phone call. The staff member stated the AP yelled at the client again and unplugged the phone cord. The client reacted by pounding on the wall and the AP reacted by pounded back on the other side of the wall. The staff member stated the AP's actions were disturbing, therefore he intervened. The staff member stated the AP's actions caused the client to be in an extreme state of fear and distress but could not recall the exact words the AP said to the client because it happened so fast.

During interview, the client's former case manager stated she was aware of the incident and the client had told her that staff were not always patient with him and were sometimes rude. She stated that the client has gone through many changes and has been in multiple facilities since this incident.

During interview, the program director stated that the client was interactive and high functioning. The director stated that during this incident, the AP asked the client to leave while the staff were in a meeting and the yelling went back and forth; it was a power struggle. The director stated the AP admitted taking the phone away during the incident but had reasons why she handled the situation that way. He stated the client previously expressed that he wanted to move, and this incident made him want to move even more.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: No. The client is no longer at the facility.
Family/Responsible Party interviewed: No. Family did not respond to requests for interview.
Alleged Perpetrator interviewed: The AP was contacted and informed of the investigation but did not respond to phone calls for the interview.

Action taken by facility:
The facility conducted an internal investigation. The AP was placed on administrative leave during the investigation and no longer works at the facility.

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.

You may also call 651-201-4200 to receive a copy via mail or email

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 Mental Health and Developmental Disabilities
Ramsey County Attorney

Shoreview City Attorney
Shoreview Police department

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 12/06/2022

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. On November 22, 2022, the Minnesota Department of Health investigated an allegation of maltreatment, complaint #HG208188M. The following correction order is issued for #HG208188M, tag identification 0700, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	5 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies"	

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5 000	Continued From page 1	5 000	column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by. " Following the investigators ' 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/RULES.	
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	5 700		

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5 700	Continued From page 2 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one client reviewed (C1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	5 700	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	