Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:
HG3828064M/HG3828005M
Compliance #: HG3824463C

Date Concluded: May 29, 2024

Name, Address, and County of Licensee Investigated:
Shingle Creek Option
5624 73rd Avenue North
Brooklyn Park, Minnesota 55429
Hennepin County

Facility Type: Intermediate Care Facility (ICF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP) abused a resident when the AP hit the resident near his eye. The resident sustained a cut which required treatment at an emergency department (ED).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP hit the resident in the face, leaving a cut shaped like a ring next to his right eye which required medical attention.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian and law enforcement. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident report, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in an intermediate care facility. The resident's diagnoses included autism and intellectual disability. The resident's care plan included assistance with medication administration, as well as monitoring and handling behaviors such as aggression towards others. The resident's individual abuse prevention plan (IAPP) identified the resident as susceptible to abuse and unable to defend himself from abuse from others. The IAPP also identified the resident as unable to report instances of aggression from staff.

The AP wrote a progress note in the resident's medical record, indicating the resident was agitated the morning of the incident. The resident woke up at 1:00 a.m. and wanted to get dressed. The AP indicated the resident grabbed and scratched her when she told him no. The resident went to his room and started slamming things. The resident had a small cut on his right eye, but the AP did not know how it got there.

The facility's internal investigation indicated the resident sustained a cut next to his eye. Staff members cleaned the area and the bleeding stopped. At the nurse's request, staff brought the resident to urgent care. An urgent care provider instructed staff to bring the resident to the ED for stitches. At the ED, the provider could not stitch the cut and instead applied a glue compound to keep the cut closed. The internal investigation included interviews with multiple staff members. Unlicensed personnel (ULP)-1 stated she came in at 6:00 a.m. to start her shift. She noticed the resident's bedroom light on. Upon entering the room, she saw him sitting up in bed with blood on his face. The AP had still been in the parking lot, so ULP-1 called her to come back in, complete a progress note and incident report. The internal investigation also included an interview with ULP-2 who had been working the overnight shift in a nearby apartment. ULP-2 stated the resident woke up around 1:00 a.m. and became agitated; wanting to get dressed and have breakfast. At 3:00 a.m., ULP-2 checked on the resident who had been relaxing on his bed with no injury. ULP-2 did not hear or see anything after the 3:00 a.m. check. The internal investigation indicated several staff spoke with the executive director and told him they suspected the AP hit the resident by the way she had been acting outside of work over the weekend. Additionally, multiple staff informed the director of operations (DO) the AP admitted she hit the resident.

An image of a text message indicated the AP wrote she felt like she had to protect herself from the resident. The text message also indicated the resident put his hands on her, and the facility needed to teach the resident to keep his hands to himself. The AP wrote staff at the facility were acting like it was her fault, but no one had any proof.

Images obtained from facility staff showed the resident sustained an injury next to the right eye, resembling three curved cuts, creating an oblong shape. The resident's face also had swelling to the right of the eye and redness throughout the area.

The AP's personnel record indicated she received two eight-hour shifts of training on the resident. The training consisted of seven hours observing, seven hours followed by a supervisor,

and two hours reading the resident's record including service plan, risk management, and the program book. The document indicated the AP received training on the resident's challenging behaviors, communication style, and general approaches, as well as individual characteristics. The AP's personnel record also included documentation the AP signed off on understanding the protocols for neglect, abuse, and suspected abuse, as well as resident falls, injury, and illness. Additionally, the AP successfully completed training on vulnerable adult mandated reporters which included knowledge of Minnesota's Vulnerable Adults Act. The AP's personnel record did not include evidence of successfully clearing a background study.

During email correspondence, the executive director indicated the AP's background study never cleared.

During an interview, the executive director stated he arrived at the facility after receiving a call from facility staff, informing him of the resident's injury. The AP did not complete an incident report and had poor notes for the shift. The executive director started an investigation and suspended the AP. He searched the environment and looked for any blood to indicate he fell and hit his eye. Over the next few days, he started to receive concerns from multiple staff members, in which the AP had alluded to hitting the resident. After the incident, the resident seemed hesitant around staff, probably fearful of what happened. The executive director stated he changed their policy so newly hired staff could not work in the apartments until they either cleared a background study, or the facility received a letter from the Department of Health Services (DHS) indicating they could work with supervision.

During an interview, the DO stated she took part in the internal investigation. The AP told her the resident slipped on water in the doorway coming into the apartment, but the floor had carpeting on both sides. Additionally, there were no signs he slipped and fell there, or anywhere else in the apartment. The resident's injury looked like a mark caused by a large ring. The DO stated she had previously seen the AP wear a ring.

During an interview, ULP-2 stated she saw the resident in the morning after being notified by ULP-1 of the injury. ULP-2 saw the resident bleeding and thought it looked like someone hit him. Although nonverbal and not able to say what happened, the resident flinched when asked if someone hit him. The resident did return to his baseline.

During an interview, ULP-3 stated the AP's story about what happened kept changing, and at one point asked, "what if it was you?" ULP-3 stated the AP told her at one point the resident fell and hit his head, but at another point stated the resident choked her, so she pushed him and then he fell. ULP-3 stated she did not believe any version of the AP's story and thought she hit him. After the incident, the resident seemed jumpy and scared.

During an interview, ULP-4 stated the resident seemed skittish for a couple of days after the incident but did return to his baseline. ULP-4 stated he saw the injury and looked similar to an

emerald cut diamond. ULP-4 thought the resident had been punched due to swelling around the eye socket.

During an interview, the AP stated the resident woke up between 1:00 a.m. and 3:00 a.m. He used the restroom and tried to get dressed. The AP told the resident to lay back down, which he did. Towards the end of the shift, the AP went to get the resident's clothes for the day due to them being kept downstairs. The resident had been asleep. The AP spoke with ULP-1 who then went into the building and called her. ULP-1 called the AP before the AP left the parking lot and informed her the resident had been bleeding. During the interview, the AP denied slapping, hitting, or striking the resident in any way. The AP denied sending the text message and stated anyone could have used her name in their contacts.

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;
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;

Vulnerable Adult interviewed: No. The resident was nonverbal and unable to effectively communicate for an interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed at the facility. The facility completed an internal investigation and contacted law enforcement. Additionally, the facility completed education with staff and installed cameras in the main area of the living space.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01430	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE CREEK OPTION	5624 73RD AVE NO BROOKLYN PARK, MN 55429

(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 #HG3828064M/HG3828005M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #HG3828064M/HG3828005M, tag identification 0700.	5 000		

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5 700	Continued From page 1	5 700		
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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual 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 is required for this tag.	