Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL237492343M
Compliance #: HL237491409C

Date Concluded: June 25, 2024

Name, Address, and County of Licensee Investigated:
Dr. Thomas Johnson House HWS
2221 W 55th Street
Minneapolis, MN 55419
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, RN
Special Investigator

Finding: Inconclusive

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) physically abused the resident when a staff member struck the resident in the face during an altercation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to incomplete and conflicting accounts of the incident, it could not be determined if maltreatment occurred.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator also contacted a member of the resident's family. The investigation included review of resident records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included cognitive impairment, bipolar disorder, and anxiety. The resident's service plan included assistance with activities of daily living, medications, meals, housekeeping, as well as transfer and repositioning assistance. The resident's assessment included a history of mood disorder diagnoses including anxiety, depression, and bipolar disorder. Other documented concerns included poor decision making and a history and risk of self-abuse.

A review of facility documentation indicated the resident became agitated with a staff member/alleged perpetrator (AP) over the purchase of cigarettes. When the AP's de-escalation attempts failed, the resident became physically and verbally abusive. The AP indicated that at one point he was struck by the resident, although additional documentation indicated that during the altercation the AP struck the resident in the face.

During an interview, an unlicensed staff member who was on duty at the time of the incident, stated that they heard the altercation, intervened, and instructed the AP to leave the facility. The nurse was contacted and informed of the incident.

The facility nurse assessed the resident the following morning and there was no presence of injury, no facial swelling, no abrasions, cuts, or bruising and no indication of being struck in the lip or face area.

During an interview with the resident, the resident stated that at the time of the incident he was putting someone out of his room and forced them to leave, then they punched me in my face. The resident was not able to identify an AP other than that they thought the person was a new employee. The resident stated that they had no concerns with the facility. The resident felt safe and enjoyed living there.

During an interview, an administrative employee stated that immediately after the alleged altercation occurred, the AP was asked to leave the facility and the incident was reported to management and nursing for review.

During an interview with a facility nurse, the nurse stated she was notified of the incident by staff members who were working at the time of the incident. Once notified, an internal investigation was initiated, and a member of the nursing staff assessed the resident for injuries. The internal investigation was unable to verify what occurred, as the altercation was unwitnessed.

During an interview with the resident's family member, they stated they were not contacted by the facility about the incident. When they inquired about the incident after being told about it by the resident, they were told that the staff member had been reassigned and the incident was being investigated by the facility. The family member did not have concerns with the care provided at the facility.

The AP did not respond to requests for interview.

Attempts to contact the resident's case manager for interview were not successful.

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:
(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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, attempts to contact were unsuccessful

Action taken by facility:
The facility initiated an internal investigation. The AP was retrained and assigned to another work location.

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
	23749	A. BUILDING: _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR THOMAS H JOHNSON HWS	2221 WEST 55TH STREET MINNEAPOLIS, MN 55419

(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 On May 29, 2024, the Minnesota Department of Health initiated an investigation of complaint #H237491409C/#HL237492343M. No correction orders are issued.	0 000		