Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL253723706M
Compliance #: HL253726089C

Date Concluded: September 6, 2023

Name, Address, and County of Licensee Investigated:
Restart Inc.
4525 Aldrich Ave. South
Minneapolis, MN 55419
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
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):
A facility nurse/alleged perpetrator (AP) abused a resident when the AP pushed the resident to the ground in an argument over paperwork.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the resident reported the facility nurse/alleged perpetrator (AP) pushed and shoved the resident, a witness to the incident denied the physical altercation occurred. De-escalation intervention techniques were utilized by staff involved in the incident, as directed by the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, personnel files, facility policies, and procedures. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included anoxic brain injury, behavior disturbance, and intermittent explosive disorder. The resident's care plan included assistance with dressing, grooming, and medication management. The resident's assessment indicated the resident has history of agitation, verbal aggression, and anxiousness.

Progress notes indicated the incident occurred after the resident grabbed his medical chart, shredded documents from the chart, and hid them in the garbage. The note indicated the resident informed staff he planned to act out, to get kicked out of the facility.

Staff working at that time contacted the AP, who came to the facility to assist with the resident. When the AP arrived, the resident showed the AP where the documents were, grabbed the documents, ran upstairs, and put the documents in his pants. The AP asked the resident for the documents and the resident pulled them out of his pants, placed them in the sink, and turned on the water. The AP removed the documents from the sink and walked back into the office. The progress note indicated de-escalation techniques and a calm approach were used to address the situation.

During an interview with the AP, the AP recalled when the resident put the documents in the sink, she removed them and walked back into the office. The AP stated the resident followed her out of the room and she utilized de-escalation techniques to calm the resident. The AP denied a physical altercation occurred and denied pushing or shoving the resident.

During an interview, the resident stated he ripped up a piece of paper and the AP got mad. The resident stated he put the paper in his pants and the AP reached in his pants to obtain the paper. The resident stated the AP pushed and shoved the resident and the AP was telling the resident what to do.

During an interview, a facility staff member working at the time of the incident, stated she saw the resident take the papers, rip them up, and put them in his pants. The staff member stated the AP did not touch, push, or shove the resident.

During an interview, facility management stated the resident normally reported concerns, however, the resident did not report this incident.

During an interview, the resident's guardian stated the resident did not report this incident until one week later, when he was in the hospital, and at that time he did not report physical abuse.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: Yes

Action taken by facility:
The facility developed interventions and de-escalation techniques which were utilized during the incident.

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
	25372	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	4525 ALDRICH AVENUE SOUTH 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 July 10, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL253726089C/#HL253723706M. No correction orders are issued.	0 000		