

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL262503243M
Compliance #: HL262505251C

Date Concluded: May 3, 2023

Name, Address, and County of Licensee

Investigated:

Tolad Incorporated
516 Brookdale Drive
Brooklyn Park, MN, 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal RN, BSN
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):

The alleged perpetrator (AP), facility staff, abused a resident when they punched and threw a chair at the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. The resident initially reported he was injured when the AP punched him and threw a chair at him. However, it was determined the resident punched the AP. The AP denied punching the resident or throwing a chair at the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and case managers. The investigation included review of the residents medical, social service, legal and law enforcement records. In addition, facility incident reports, facility policy and procedures and the AP personnel file reviewed.

The resident resided in an assisted living facility with diagnoses including pervasive developmental disorder, personality disorder, schizoaffective disorder, and intermittent explosive disorder. The resident required assistance with medication administration, twenty-four-hour awake staff for behavior observation and frequent intervention for safety and supervision.

Facility staff managed the resident's cigarettes which were stored in a locked cabinet and dispersed at specific times per the residents individualized plan.

A facility incident report indicated one afternoon the resident asked the AP for a cigarette and the AP told the resident it was not time for a cigarette. The resident was angry with the AP and punched the AP in the mouth. The AP called 911 and facility management for assistance.

A law enforcement (LE) report indicated the resident contacted 911 because he needed his cigarettes and facility staff would not give the resident his cigarettes. A separate call to 911 indicated facility staff called 911 stating that the resident was "up in the staff's face" demanding his cigarettes. When LE arrived the resident and AP were outside. The AP stated the resident was allowed a certain number of cigarettes per day and the resident was not allowed anymore at that time. When the AP did not give the resident his cigarettes the resident hit the AP numerous times in chest and shoulder and eventually punched the AP in face resulting in a swollen lip, laceration and AP spat blood from his mouth. The resident became more and more agitated and, "Due to statements and marks" the resident was written a citation. The resident continued to be verbally aggressive and advised by LE to go to a separate area to cool down as his behavior was not acceptable. The resident eventually went to his bedroom.

The law enforcement report indicated shortly after law enforcement left the facility, the resident called 911 again. The resident reported he had rib pain because of the altercation with the AP and the resident wanted to go to the hospital. Paramedics transported the resident to the hospital. The LE report indicated the facility needed to come up with a different plan to manage the resident's cigarettes because the current plan resulted in numerous 911 calls.

During an interview with a case manager, she stated the resident was evaluated at the hospital for an unspecified injury to the rib. The resident had no treatment or further evaluation and returned to the facility the same day. The case manager stated the resident had history of verbal and physical aggression and cigarettes were a common trigger for the resident.

During interview with facility administration, they stated the resident behavior escalated quickly and often calling 911 was the only option to control the residents' violent behaviors. They stated the AP sustained injury from the altercation with the resident, he had to seek medical treatment, and filed a workman's compensation claim. Administration stated others sustained injury from the resident in the past

During interview with the assisted living director, it was reported the AP notified the office immediately after the incident occurred. The director explained due to the AP injury and necessary medical treatment the facility filed a workman's compensation claim.

During interview the AP stated he was not aware the resident made the allegation he hit the resident with a chair and punched him. The AP stated the day of the incident the resident got angry when he couldn't have a cigarette. The AP stated the resident punched him multiple times, and the AP was able to "escape" from the resident and rushed outside to call 911. The AP stated he went to urgent care following the incident and completed paperwork related a workman's compensation claim for the injury. The AP stated he has never punched the resident or thrown a chair at the resident.

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: No.

Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

Called 911

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2023
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NAME OF PROVIDER OR SUPPLIER TOLAD INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 516 BROOKDALE DRIVE BROOKLYN PARK, MN 55444
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(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	<p>Initial Comments</p> <p>On March 7, 2023 the Minnesota Department of Health initiated an investigation of complaint HL262504326C, and HL262503243M/HL262505251C. No correction orders are issued</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____