Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334252769M
Compliance #: HL334254705C

Date Concluded: June 29, 2023

Name, Address, and County of Licensee Investigated:
Restful Home LLC
1000 Reaney Ave.
St. Paul, MN 55106
Ramsey 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 staff member/ alleged perpetrator (AP) abused the resident when the AP rummaged through the resident's belongings, yelled, cursed, and blocked the doorway, forcing the resident to stay in an uncomfortable, unsafe, situation until the police arrived.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP's actions were disrespectful and unprofessional, there was not a preponderance of evidence the actions met the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case manager. The investigation included review of the resident's medical record, police reports, personnel files, and 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 diabetes, peripheral neuropathy, and chronic back pain. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was alert and orientated to person, place, and time, and could verbally communicate his needs.

The resident's medical record identified an incident occurred between the resident and a staff member. The medical record indicated the resident called his case manager and said he didn't feel comfortable, was upset, and the case manager heard yelling in the background. A staff member/alleged perpetrator (AP) accused the resident of stealing her phone and went through the resident's belongings without the resident's permission. When the resident requested for the AP to stop, the AP threatened to hurt the resident or have him hurt, if she didn't get her phone back. Administrative staff arrived at the facility during the incident but did not de-escalate the situation and police were called. The resident attempted to leave the facility, but the AP blocked the door, refusing to allow the resident to leave until police arrived.

The police report indicated their assistance was needed to de-escalate the situation and identified the incident as a "he said, she said" case. The case was closed, and no charges were filed.

During an interview, administrative staff stated they became aware of the incident when they were contacted by the resident because the AP accused the resident of stealing her phone. Administrative staff went to the facility and found the AP angry and swearing at the resident. The AP refused to leave the resident's room and continued yelling. Administrative staff called 911 to have the police deescalate the AP's behavior. The police and administrative staff reviewed camera footage which confirmed the resident did not take the AP's phone and the AP was sent home.

During an interview, the case manager indicated she was on the phone with the resident at the time of the incident and could hear the AP yelling. The case manager also recalled she attempted to talk to administrative staff, but staff declined. When police arrived, the call with the case manager was ended, per their request.

During an interview, the resident stated the AP lost her phone and thought the resident took it. The resident recalled there was a lot of yelling back and forth between him and the AP. The resident felt "trapped" in his room because the AP kept telling him he couldn't go anywhere. The resident denied being scared or afraid and said that was the only incident that had occurred between him and the AP.

Attempts to contact the AP were unsuccessful.

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: No, no family available.
Alleged Perpetrator interviewed: No, attempts to contact AP were unsuccessful.

Action taken by facility:
The facility called the police to deescalate the situation.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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
	33425	A. BUILDING: _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL334254705C/#HL334252769M On June 8, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 8 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL334254705C/#HL334252769M, tag identification 1470, 2350 and 2410.	0 000		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	01470		

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01470	Continued From page 1 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	01470		

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01470	Continued From page 2 (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all required content for two of two employees (unlicensed personnel (ULP)-C and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on July 16, 2022, to provide direct care to residents. ULP-C's employee record did not include the following required orientation content: - an overview of the 144 G statutes - an introduction and review of the facility's	01470		

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01470	Continued From page 3 policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure ULP-D ULP-D was hired on April 21, 2023, to provide direct care to residents. ULP-D's employee record did not include the following required orientation content:	01470		

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01470	Continued From page 4 - an overview of the 144 G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure During an interview on June 8, 2023, at 12:20 p.m., nurse consultant (NC)-F confirmed ULP-C and ULP-D's records did not include all required content and indicated the licensee was working	01470		

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01470	Continued From page 5 on implementation of education for corrections. The licensee's Orientation & Training policy dated July 1, 2021, indicated all staff providing direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interviews, and record review, the licensee failed to ensure one of one resident (R1) reviewed, was treated with dignity and respect when unlicensed personnel (ULP)-C swore and yelled at the resident and went through the resident's personal property without the resident's permission. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	02350		

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02350	Continued From page 6 The findings include: R1 admitted to the licensee on April 29, 2022, with diagnoses including diabetes, peripheral neuropathy, and chronic back pain. A police report dated August 30, 2022, identified report of a disorderly disturbance at the facility. The report identified a resident was very angry and a phone was missing. The police report identified the incident as a "he said, she said" and their assistance was needed to de-escalate the situation. During an interview on June 8, 2023, at 11:15 a.m., R1 stated ULP-C lost her phone and thought R1 took it. R1 stated there was a lot of yelling back and forth between him and ULP-C. R1 stated he felt "trapped" in his room because ULP-C kept yelling that R1 couldn't go anywhere. R1 felt he couldn't leave his room because the police, administrative staff, and ULP-C were outside his door. During an interview on June 8, 2023, at 12:30 p.m., licensed assisted living director (LALD)-A stated R1 called LALD-A because ULP-C was accusing R1 of taking ULP-C's phone. LALD-A stated when he arrived at the facility ULP-C was angry and swearing at R1. ULP-C refused to leave R1's room and continued yelling. LALD-A called 911 to have the police deescalate ULP-C's behavior. LALD-A reviewed camera footage with the police and identified R1 did not take ULP-C's phone. ULP-C was sent home. LALD-A stated there were other incidents that occurred with ULP-C, but LALD-A did not have documentation of any disciplinary action or reeducation provided to ULP-C.	02350		

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02350	Continued From page 7 The licensee's undated Code of Conduct indicated the staff shall possess a professional attitude and will not participate in any unprofessional activities including swearing while on the job. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02350		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.	02410		

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02410	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's right to consideration of their privacy and personal property for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on April 29, 2022, with diagnoses including diabetes, peripheral neuropathy, and chronic back pain. R1's medical record indicated an unlicensed personnel (ULP)-C went through R1' belongings without the R1's permission. When R1 requested ULP-C to stop, ULP-C threatened R1 and stated she will catch him outside or would hurt him inside the building, if she didn't get her phone back. During an interview on June 8, 2023, at 11:15 a.m., R1 stated ULP-C lost her phone and thought R1 took it. R1 stated ULP-C went through R1's belongings looking for ULP-C's phone. During an interview on June 8, 2023, at 12:30 p.m, licensed assisted living director (LALD)-A confirmed ULP-C went through R1's property	02410		

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02410	Continued From page 9 without R1's consent when ULP-C thought R1 took her phone. During an interview on June 12, 2023, at 2:00 p.m., case manager (CM)-E stated staff entered R1's room without R1's permission. CM stated there was a lock on R1's door but staff would use a butter knife to pop the lock to enter R1's room. During an email correspondence June 13, 2023, LALD-A indicated no staff are allowed to search a resident's room or belongings without consent. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, indicated, Residents have the right to have a lockable door to the resident's apartment. The resident has the right to privacy and the staff must respect the resident's privacy by seeking consent before entering the resident's apartment. The licensee's 2.05 Bill of Rights policy dated July 2, 2021, revised August 1, 2021, indicated staff would be trained on concepts and rights in the bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		