Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360582141M
Compliance #: HL360583887C

Date Concluded: January 6, 2023

Name, Address, and County of Licensee Investigated:
Astral Home Care
9121 Barrington Terrace
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 yelled at the resident, punched the resident in the chest, and kicked the resident. It is also alleged the facility neglected the resident when the resident expressed suicidal thoughts and staff did not prevent him from leaving the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were not substantiated. The facility had multiple interventions for staff to use in the event the resident started becoming aggressive. The facility trained the AP, and the AP used those interventions. The resident had a pattern of reporting suicidal thoughts to 911 without talking to facility staff and was able to leave the facility independently.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian and case

manager. The investigation included review of resident records, incident reports, law enforcement reports, policies, and procedures related to resident rights, resident services plans, facility scope of service, and maltreatment of vulnerable adults. Also, the investigator observed staff interactions with the residents.

The resident lived in an assisted living facility per a civil commitment. The resident's diagnoses included autism spectrum disorder, fetal alcohol spectrum disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, mild intellectual disability, diabetes, and personality disorder. The resident's service plan included assistance with medication management, diabetes management, mental health/behavior management, community integration, meals, scheduling, and transportation to appointments.

The resident's behavior plan indicated the resident struggled with agitation, anxiety, impulsivity, and physical aggression. The resident's plan provided multiple methods and actions for staff to use to support the resident which included frequent positive reinforcement, use of structure, modeling of appropriate social skills, concrete expectations, use of humor, giving the resident choices, asking the resident's opinion, providing one to one time, and keeping the resident busy with activities (sports, artwork, and outside time).

According to an incident report, one evening the resident ate his dinner and then ate a peer's dinner. The AP approached the resident to talk about this behavior. The resident quickly became angry and verbally threatened the AP. The resident then began to break furniture and got in the AP's face. Staff called 911 and when the police officers arrived, they suggested they take resident to the crisis center. When the resident arrived at the crisis center, he told staff the AP punched and kicked him.

During an interview, a management staff stated the resident had behavioral issues surrounding food. The resident would take others' food, so the facility placed the food supply in a secure area. The resident thought he could have whatever food he saw. The management staff spoke with staff and residents who were present during the incident and found the AP moved away from the resident to protect himself but did not punch or kick the resident. The management staff stated the facility nurse attempted to assess the resident after the interaction.

During an interview, the nurse stated the resident had diabetes so the resident could not eat whatever he wanted. The nurse stated the resident was often quick to put up his fists and punch others (staff and residents). The nurse stated the resident often called 911 without facility staff knowledge and would then just leave the facility. The nurse stated the resident liked going to the hospital.

During an interview, the guardian stated the resident had difficulty with placements due to impulsivity and aggression but was learning to recognize consequences of some of his behaviors. The guardian stated the facility did a good job managing the residents behaviors.

During investigative interviews, multiple staff members stated the resident had difficulty with impulsivity and accepting natural consequences of his behavior (such as when he broke something, he could no longer use it). The staff stated the most important part of their job was to build relationships with the residents and learn about their triggers and early warning signs.

During an interview, the resident stated he liked living at the facility which was his house. The resident stated he sometimes got into trouble for fighting but did not mean to hurt anyone. The resident stated he hoped to soon get a job.

During an interview, the AP stated he worked well with the resident as he got to know him. The AP stated the resident did not like when staff told him no, so when the AP told him not to eat the other resident's food the resident got very mad. The AP stated the resident threw punches at him and did fall, but the AP did not hit or kick the resident. The AP stated the resident blamed him for injuries because the resident loved to ride in an ambulance and go to the hospital.

In conclusion, abuse and neglect were 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;

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

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
	36058	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTRAL HOME CARE LLC	9121 BARRINGTON TERRACE BROOKLYN PARK, MN 55443

(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 Initial comments On December 13, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL360583887C/#HL360582141M. No correction orders are issued.	0 000		