Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360998445M
Compliance #: HL360995667C

Date Concluded: March 1, 2024

Name, Address, and County of Licensee Investigated:
Prestige Home Health Care LLC
6124 81st Ave. North
Brooklyn Park, MN 55443
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):
The alleged perpetrator (AP), a facility staff, abused a resident when the AP was rude and hit the resident's hand with a phone during an altercation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the resident had bruising on her arm, there was not a preponderance of evidence to support that the bruising was a result of the AP hitting the resident with a phone. The AP attempted de-escalation interventions at the time of the incident. When de-escalation techniques were unsuccessful, the AP contacted the police for assistance.

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, hospital records, police reports, personnel files, and facility policies and procedures. At the time of the onsite

investigation, 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 autism spectrum disorder, mood disorder, and major depression. The resident's care plan included assistance with medication management and behavior support. The resident's assessment indicated the resident had a history of physical aggression and was alert and orientated.

Facility documentation indicated the resident got upset when she returned to the facility and did not get the fast food the other residents received. The resident jumped on the staff member/alleged perpetrator (AP) and began yelling, kicking, and throwing things. The police were called, and the resident was taken to the hospital.

A police report indicated the resident jumped on the AP, wrapped her legs around the AP, and pulled the AP to the ground. The police report detailed no evidence of the AP hitting the resident with a phone and no charges were filed against the AP.

During an interview, the AP stated the resident was upset about not getting fast food. The AP told the resident she would get the resident fast food and attempted to walk away, but the resident's agitation increased. The AP stated the resident jumped on her, wrapped her legs around her, pulled her down to the ground and broke her phone. The AP yelled for another resident to call 911. When police arrived, they had to pry the resident off of the AP. The AP denied hitting the resident.

During an interview, facility management reported they watched video footage at the time of the incident and reviewed the footage again the next day. In the video, the AP attempted to de-escalate the situation. Facility management stated the AP did not hit the resident with a phone. Following the incident, all staff were re-educated on de-escalation techniques.

During an interview, the resident's family member reported that the resident had a history of altercations with staff; however, the number of altercations have decreased following this incident.

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; Resident unavailable for interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility contacted police and re-educated staff on de-escalation techniques.

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
	36099	A. BUILDING: _____ B. WING _____	C 02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE HOME HEALTH CARE LLC	6124 81ST AVENUE NORTH 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 On February 5, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL360995667C/#HL360998445M. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	