Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366671920M
Compliance #: HL366679724C

Date Concluded: March 19, 2024

Name, Address, and County of Licensee Investigated:
All Wullancare Inc.
7433 Lee Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

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) abused a resident when the AP threw the resident down to the ground and restrained him, which resulted in the resident receiving a fractured nose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Surveillance video showed the resident initiated the altercation and the AP defended himself from the resident's physical aggression initially, then the AP threw the resident down to the floor and restrained the resident for over seven minutes until police arrived.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and reached out to law enforcement. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement

report, related facility policy and procedures. Also, the investigator observed staff/resident interaction.

The resident lived in an assisted living facility for several years with diagnoses including schizophrenia and antisocial personality disorder. The resident's service plan included assistance with medication administration and behavior management. The resident's behavior plan provided multiple interventions for staff to use when the resident was agitated, verbally aggressive, or physically aggressive.

An incident report indicated the resident was verbally and physically aggressive with a peer and staff. The report indicated the resident was name-calling a peer and yelling at him. The report indicated the AP redirected the resident, but the resident continued yelling and threatening. The resident attacked the AP who placed the resident on the floor for safety until the police removed the resident. The report did not indicate the AP restrained the resident.

Surveillance video of the incident was reviewed by the investigator. In the video the resident was observed yelling, swearing, and appeared agitated. The resident initially targeted a peer who was sitting at a table. When the AP began talking, the resident charged at the AP who sat in an adjoining room. The resident yelled and grabbed the AP's sweatshirt, pulling it off. The AP stood up and moved toward the resident in a hallway and the AP grabbed the resident's shirt, stating he was going to call the police. The resident moved away and threw liquid and a cup at the AP, then charged at him. They each grabbed onto the other and the AP blocked punches from the resident as they moved around the kitchen area. The AP grabbed the resident's arms, moved the resident out of the kitchen, and yelled "call the police!" The AP grabbed the resident's sweatshirt and threw him down to the floor. The AP straddled the resident, then placed the resident's hands under the AP's knees. While the AP restrained the resident, the resident screamed several times, "I can't breathe" and "Get off me!" The resident stated he was sorry, then called the AP the "N" word, said "F… YOU!!, you're beating me up!" The video showed the AP restrained the resident for over seven minutes until officers arrived.

A law enforcement report indicated the facility called for mental health assistance. The report indicated when they arrived, they placed the resident on a transport hold, and brought the resident to the hospital.

Hospital records indicated the resident had a closed fracture of the nasal bone. The hospital discharged the resident on sinus precautions due to the fracture. The precautions directed the resident to not smoke, not blow his nose, not sneeze with his mouth open, not sniffle, not drink with straws, or do anything which might create pressure in the sinus cavity. The records indicated the resident could possibly have bleeding or drainage that would stop as healing occurred.

During an interview, a nurse stated the facility implemented interventions for staff to use with the resident's aggression and trained all staff through meetings, one-to-one orientation, and

computer trainings. The nurse stated the AP stated he redirected the resident, which did not work in this incident, they fought, and the AP took the resident down to the floor. The nurse stated the AP held the resident down and waited for law enforcement.

During an interview, the AP stated the resident had consumed multiple energy drinks and coffee prior to the incident and was agitated. The AP stated he witnessed the resident's interaction with a peer and became concerned when the resident was yelling and screaming at the peer and eventually got up from sitting at the table with the peer. The AP stated he was concerned about the safety of the peer when the resident slammed the chair he was sitting in against the table. The AP stated he asked the resident why he slammed the chair and the resident charged over to where the AP was sitting. The AP stated the resident grabbed the AP's hair, pulling some out, and pulled off the AP's hoodie. The AP stated he got up, held the resident by the shirt sleeves, and told the other staff to call police. The AP stated the resident then grabbed the AP and shoved him into the kitchen against the counter/sink area. The AP stated the resident threw hot coffee on him and hit him in the face with a coffee cup. The AP stated the peer got up from the table and tried to intervene, but the AP told him to move away.

The AP stated he could not recall how he got the resident onto the floor. The AP stated he straddled the resident, with one leg on each side of the resident's chest, which prevented him from moving. The resident laid on his back, and the AP restrained the resident's hands by placing them under the AP's knees. The AP stated he told the resident he needed to stay there until the police arrived. The AP stated the resident got a hand free and grabbed the AP's crotch, so the AP held the resident's hands with his hands until the police arrived. The AP stated he never put his weight on the resident's body.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;
(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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult.

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

Action taken by facility:
The facility investigated the incident, reviewed surveillance video, reassessed the resident, and updated his service plan.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36667	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL WULLANCARE INC	7433 LEE 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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL366679724C/#HL366671920M On March 5, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 2 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL366679724C/#HL366671920M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	