Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371334001M
Compliance #: HL371334509C

Date Concluded: August 29, 2024

Name, Address, and County of Licensee Investigated:
Obed Edom
7388 Symphony S NE
Fridley MN 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier
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 facility neglected a resident when resident #2 punched resident #1.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it is true resident #2 punched resident #1, the facility could not have reasonably anticipated this event.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of facility records, medical records, law enforcement records, employee records and facility policies.

Both residents resided in an assisted living facility. Resident #1 diagnoses included substance abuse, post-traumatic stress disorder, depression and anxiety. Resident #1 service plan included

assistance with medication administration. Resident #1 assessment indicated the resident often misused alcohol and was independent with all activities of daily living.

Resident #2 diagnoses included post-traumatic stress disorder, and major depression disorder. Resident #2 service plan included assistance with medication management, bathing, grooming and food preparation. Resident #2 assessments indicated the resident was able to verbalize his needs to staff appropriately.

An incident report indicated one day resident #1 and resident #2 were outside the facility on the facility grounds when a staff member heard them arguing. The document indicated the staff member went to the area where the residents were and witnessed resident #2 punch and kick resident #1 in the face. The staff member called for law enforcement immediately as he tried to separate the two residents.

The same document indicated when police officers arrived, they removed resident #2 from the area. The facility sent resident #1 to the hospital via ambulance at the same time for evaluation.

During an interview, the facility leadership stated neither resident had any previous behaviors such as prior to this event to anticipate resident #2 would be aggressive to resident #1.

During an interview, the staff member stated he was making the residents dinner when the two residents started yelling. The staff member went to the residents immediately, separated the resident, called 911 and the facility director, who came to the facility immediately. The staff member stated he was surprised resident #2 hit and kicked resident #1 but did what he could at the time to keep both residents safe.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: attempted

Family/Responsible Party interviewed: not known
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility protected the residents from further harm and called the police immediately. The facility also sought appropriate care for resident #2 and reported the incident to the required agencies. The residents no longer live at the same facility.

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
	37133	A. BUILDING: _____ B. WING _____	C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OBED-EDOM ASSISTED LIVING	7388 SYMPHONY STREET NE FRIDLEY, MN 55432

(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 August 19, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL371334509C/#HL371334001M. No correction orders are issued.	0 000		