Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL372515344M
Compliance #: HL372519104C

Date Concluded: October 31, 2023

Name, Address, and County of Licensee Investigated:
Senative Services
11406 Quebec Avenue
Champlin, MN 55316
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility 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 facility neglected resident #1, resident #2, and resident #3 when they failed to ensure the residents were safe from physically abusing each other. This resulted in a violent altercation between the residents. Resident #2 stabbed resident #1 in the neck with a screwdriver. Resident #1 was treated at a hospital for his injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's assessments and care plans identified the residents as being verbally and physically aggressive. Although staff were trained to redirect and de-escalate potential hostile interactions, a facility video camera captured a facility staff member sat close by and listened when resident #1, resident #2, and resident #3 exchanged hostile words and never attempted to redirect resident #1 and resident #3 as they approached resident #2 in a menacing manner. The facility staff member only intervened after a violent physical fight ensued between the three residents. In addition, the facility's Uniform Disclosure

of Assisted Living Services (UDALSA) indicated two staff members were to be scheduled for the morning and evening shifts, but police reports, resident interviews, and staff schedules indicated one staff member was scheduled during the time each verbal and physical outburst ensued between the residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, case workers, and family members. The investigator reviewed the resident's facility records, hospital records, mental health case management records, police reports, and employee files. In addition, the investigator observed resident and staff interactions during the onsite investigation.

Resident #1 resided in a small, split-level assisted living facility/group home setting. Resident #1's diagnoses included, irritability, anger, adjustment disorder with mixed anxiety, depressed mood, and auditory hallucinations. Resident #1's care plan indicated he received assistance with his personal cares and medication management. Resident #1 had a history of alcohol abuse and continued to drink heavily. Resident #1 exhibited verbal and physical aggression towards resident #2. Staff were directed to closely monitor resident #1. Resident #1 walked independently.

Resident #2's diagnoses included schizoaffective disorder, anxiety, major depressive disorder, post-traumatic stress disorder (PTSD), and suicidal ideation. Resident #2's care plan indicated he had difficulty concentrating and became easily confused when disoriented. Staff were directed to ensure resident #2's safety and reorient the resident to his environment, provide constant supervision, reassurance, and comfort. Resident #2 walked independently.

Resident #3's diagnoses included major depressive disorder, PTSD, and methamphetamine use disorder. Resident #3's care plan indicated he received assistance with personal cares and medication management. Resident #3 was physically and verbally aggressive and easily angered at times. Staff were to redirect the resident #3 when he exhibited signs of aggression. Resident #3 walked independently.

Review of police reports indicated on August 31, 2022, police were dispatched to the facility due to a fight between resident #1 and resident #2. Resident #1 repeatedly punched resident #2 in the face after an argument about food. Resident #2 sustained serious facial injuries. Resident #2 stated resident #1 always bullied him. Resident #2 was transported to a hospital where he received stitches for his injuries. Administrative and facility staff agreed to keep the residents separated according to a police request.

The next day police returned to the facility after resident #2 called 911 to report resident #1 assaulted him again. Resident #2 stated resident #1 stood in the doorway between their rooms in the basement and appeared to want to shake resident #2's hand. Resident #2 refused, so resident #1 struck resident 2 in the jaw. Resident #2 went upstairs to tell a facility staff member to call 911 but stated after 45 minutes passed without any police presence, he called 911,

stating he did not think staff called police. Police questioned the facility staff member who admitted hearing a verbal altercation from the upstairs main floor. Police observed resident #1 minimized his involvement and his story was fragmented, but resident #2's story never changed. Resident #2 stated resident #1 appeared to have no "off switch," and said resident #1's intimidating, threatening behavior had gotten worse over the last two months. Resident #1 was arrested and charged with third-degree domestic assault.

The facility lacked evidence they followed the police request from the previous day to keep resident #1 and resident #2 separated from each other to avoid further aggressions.

The facility arranged for resident #1 to move to a room on the main floor after he was released from jail.

Resident #3 was admitted to the facility in October 2022, and moved into a basement room next to resident #2.

On March 2, 2023, four police officers responded to a fight between resident #1, resident #2, and resident #3. Police dispatch stated they heard "lots of screaming" that sounded physical, and overheard a resident say, "you grabbed my fucking neck," before the phone line went silent. The facility staff member stated he watched resident #3 enter the kitchen and shove resident #2. The staff member stated he attempted to break up the fight but resident #1 grabbed resident #2's neck from behind. The staff member said he grabbed and threw an object out of the area that was in resident #2's hand but then stated he witnessed resident #2 stab resident #1 with the object (screwdriver). Resident #1 was transported to a hospital where he was treated for his neck injury. Resident #2 told police he had prior issues with both resident #1 and resident #3 and said resident #1 and resident #3 were drunk. When interviewed, resident #3 told police, "Resident #2 irritated me too bad, so I just felt like I wanted to fucking hit him." Resident #3's speech was heavily slurred with an odor of alcohol on his body. All three residents were charged with fifth-degree domestic assault (Minnesota Statute 609.2242). An administrative staff person provided police with video footage of the incident.

Review of facility video footage showed the staff member sat at his desk as resident #1 and resident #3 entered the kitchen area from the outside deck area. Resident #3 was overheard saying to resident #2, "I'm getting tired of your mouth," and proceeded to shove resident #2 in the face and head. In return, resident #2 shoved resident #3 into the kitchen island. At that point, the staff member got up from the desk and attempted to separate resident #1 and resident #3 but not before resident #2 stabbed resident #1 in the neck with the screwdriver. Eventually, the staff member was able to separate resident #1 and resident #2 but they continued to argue. Resident #1 and resident #3 left the area however, resident #3 reappeared and began an argument with resident #2 until police arrived. After reviewing the video, police arrested and charged resident #2 with second-degree assault.

Review of facility incident and law enforcement reports indicated between August 2022 and June 2023, resident #1, resident #2, and resident #3 engaged in physical and verbal aggressions five times.

Review of resident #2's case manager notes, indicated resident #2 made several attempts to speak with an administrative staff person about challenges he encountered with resident #1 but stated the administrative staff person did not want to deal with their situation or with resident #1.

When interviewed, multiple staff stated resident #1 and resident #3 were friends but neither liked resident #2. The staff members stated they were supposed to redirect and de-escalate volatile situations between the residents.

When interviewed, a facility nurse stated she was unsure if another fight would happen between the residents stating, "they have psychological issues, so you never know."

When interviewed, an administrative staff person stated he knew the residents for years and was aware of their past behaviors. The administrative staff person stated resident #1 and resident #2 got along with each other when they lived at another facility they managed. The administrative staff person stated due to resident #2's concerns that resident #1 and resident #3 ganged up on him he asked resident #2 to move to their other facility but stated he refused.

In a subsequent interview, the administrative staff person stated interventions they implemented after September 2022 incident included installing a video camera in the garage and moving resident #1 upstairs to keep the two residents separated. The administrative staff stated resident #1 and resident #2 could not be within so many feet of each other due to a law enforcement request. The administrative staff person stated they tried to make sure resident #1 and resident #2 were not in the same area and said they had resident #2 utilize the communal area downstairs to watch television and receive guests to avoid further issues. The administrative staff person stated he realized the best thing to do was to move them into separate facilities but stated they declined because the residents made their own decisions.

When interviewed, resident #2 stated resident #1 used racial slurs towards and threatened him. Resident #2 stated staff ignored the altercations because they feared resident #1 and resident #3's anger issues. Resident #2 stated previously there was a bell he rang from downstairs to ensure staff had resident #1 in his room when resident #2 went upstairs to eat but stated resident #1 would ignore staff and come out of his room while resident #2 was upstairs. Resident #2 stated he talked to an administrative staff person about resident #1 and resident #3 ganging up on him but stated the administrative staff person ignored his concerns. Resident #2 stated the administrative staff person offered to have resident #2 move to one of his other facilities but resident #2 said although he was afraid of resident #1 and resident #3, he should not be the one to move stating, "you don't move the victim." Resident #2 stated there were recent threats from resident #3 about wanting to "kick his ass."

When interviewed, resident #1's family member stated resident #1 was an easy-going guy who never caused trouble. The family member stated he told resident #1 to stay away from resident #2. The family member stated facility administrative staff never contacted him regarding resident #1's incidents even though the family member was resident #1's emergency contact person and was supposed to be notified of any change-in-condition or emergencies involving resident #1.

When interviewed, resident #2's family member stated resident #2 had ongoing issues with resident #1 and resident #3 and stated he tried to ignore the residents by isolating in his room. The family member stated the facility never came up with solutions for the ongoing issues with the residents. Resident #2's family member stated the facility never notified her about the incidents even though she was resident #2's emergency contact.

In conclusion, the Minnesota Department of Health determined neglect 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.

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. Resident #1, resident #2, and resident #3 were all interviewed.
Family/Responsible Party interviewed: Yes. Resident #1 and resident #2's family members were interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility moved resident #1 upstairs to the main level after the first violent altercation with resident #2.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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 :
Hennepin County Attorney
Champlin City Attorney
Champlin Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37251	A. BUILDING: _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATIVE SERVICES LLC	11406 QUEBEC AVENUE NORTH CHAMPLIN, MN 55316

(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****** HOME CARE PROVIDER/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: #HL372519104C/#HL372515344M On September 15, 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 three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL372519104C/#HL372515344M, tag identification 620 and 2360.	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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=F	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for three of three residents (R1, R2, R3) with records reviewed. R1, R2, and R3 were involved in a physical altercation. R1 was stabbed in the neck by R2 and required stitches. The facility was aware of the incident but did not immediately report the incident to the Minnesota Adult Abuse Reporting Agency (MAARC). 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	0 620		

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0 620	Continued From page 3 affect a large portion or all of the residents). The findings include: R1 R1's record was reviewed. R1 was admitted to the licensee on December 8, 2020, and was admitted to the facility on September 21, 2021. R1's diagnoses included auditory hallucinations, irritability, anger, adjustment disorder with mixed anxiety, and depressed mood. R1's service plan dated December 8, 2020, indicated R1 received reviews and assessments on admission, 14-days, 90-days, and as needed (prn). R1's care plan dated July 24, 2023, and completed by director of nursing (DON)-H, indicated R1 had a limited support network. R1 needed staff reminders and verbal cues to eat, dress, perform daily grooming and hygiene, and required a nurse to follow-up on his health issues and appointments. R1 required full medication management. R1 had a history of alcohol abuse and continued to drink alcohol. R1 exhibited physical and verbal aggression towards another resident (R2) and easily got angry. Staff were directed to closely monitor R1. R1's Individual Abuse Prevention Plan (IAPP) dated September 20, 2023, and completed by DON-H, indicated R1 required assistance with evacuation emergency situations. R1 was vulnerable to being abused and abusing other vulnerable adults. Staff were to monitor R1 for any vulnerable situations. R2 R2's record was reviewed. R2 was admitted to	0 620		

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0 620	Continued From page 4 the licensee on August 27, 2021, and admitted to the facility on September 21, 2021. R2's diagnoses included Schizoaffective disorder, anxiety, major depressive disorder, post-traumatic stress disorder (PTSD), and suicidal ideation. R2's service plan dated August 30, 2021, indicated R2 received assistance with grooming, dressing, bathing, meal preparation and reminders to eat, and medication management. R2's care plan dated July 18, 2023, completed by DON-H, indicated R2 had a limited support network, had difficulty concentrating at times, and became easily confused when disoriented. Staff were directed to reorient R2 to his environment and provide constant supervision, reassurance, and comfort whenever symptoms were exhibited. Staff would always ensure R2's safety. In addition, facility nurses were responsible for monitoring R2's medication supplies and reordering as needed (prn) medications. DON-H would follow-up any new orders for R2. R2's individual abuse prevention plan (IAPP) dated September 20, 2023, and completed by DON-H, indicated R2 required assistance with evacuation during emergency situations. R2 was vulnerable to being abused by others and abusing other vulnerable adults. Staff were directed to closely monitor R2 and intervene when needed. R3 R3's medical record was reviewed. R3 was admitted to the licensee on February 12, 2020, and admitted to the facility on October 7, 2022. R3's diagnoses included major depressive disorder, PTSD, and methamphetamine use disorder.	0 620		

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0 620	Continued From page 5 R3's service plan dated February 12, 2020, indicated R3 received unknown services 24 hours a day seven days a week from direct care staff, and registered nurse (RN) reviews and assessments at admission, 14-day, 90-day, and prn. R3's care plan dated August 11, 2023, and completed by DON-H, indicated R3 had a limited support network. R3 needed staff reminders and assistance for eating, grooming, oral hygiene, bladder/bowel incontinence, transportation, medication management, and laundry/housekeeping. R3's IAPP dated September 20, 2023, and completed by DON-H, indicated R3 required assistance with evacuation during emergency situations. R3 was at risk for elopement and wandering due to impulsive decisions such as leaving the facility and not returning until the following day. R3 was vulnerable to being abused and abusing other vulnerable adults. R3 had a history of attempted suicide. R3 was physically and verbally aggressive at times and was easily angered. Staff were to redirect R3. R3 experienced hallucinations and required close supervision when signs were noted. Review of the police report dated March 2, 2023, at 9:38 p.m., indicated at 8:46 p.m., ULP-A called 911 stating a fight broke out between R1, R2, and R3. Dispatch advised police officers they heard "lots" of screaming that sounded physical. One resident was heard, "you grabbed my fucking neck," before the line went silent. Four police responded. R2 told police he had past issues with R1 and recently with R3. R2 reported he was in the kitchen when R1 and R3 entered the kitchen	0 620		

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0 620	Continued From page 6 from the outside deck. R2 and R3 exchanged hostile words before R3 walked up to R2 and struck him in the face. R1 restrained R2 from behind by putting him in a headlock. R2 pulled a screwdriver out of his pocket and used it to stab R1 in the neck. R2 told police he never intended to stab R1. ULP-A stated he witnessed R3 shove R2 after they entered the kitchen and said he attempted to break up the fight. Licensed assisted living director (LALD)-D told police he would provide video footage of the incident. Review of video footage showed R2 was heard talking to R1 and R3 as they entered the kitchen, but was unclear what was said. ULP-A sat nearby looking down at his phone, and ignored the hostile verbal exchange between R2 and R3. R3 was overheard saying to R2, "I'm getting tired of your mouth," and proceeded to walk up to R2 and forcibly shove R2 in the face and head. At that point, ULP-A got up from his chair and walked into the kitchen and attempted to separate R2 and R3. R1 moved R3 to the sofa while R2 attempted to hit R3. R1 grabbed R2's neck and pulled him off R3. R2 pulled out a screwdriver from his pants pocket and stabbed R1 in the neck three or four times before officers arrived. R1 and R3 were charged with a misdemeanor fifth degree domestic assault, and R2 was charged with a misdemeanor fifth degree assault, in addition to second-degree felony assault. Review of the licensee's MAARC reports indicated on March 4, 2023, between 11:25 a.m., and 12:10 p.m., DON-H filed three separate MAARC reports for R1, R2, and R3, 38 hours after the incident. During an interview on October 23, 2023, at 10:30 a.m., DON-H stated MAARC reports should be	0 620		

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0 620	Continued From page 7 filed within 72 hours but said he tried to complete them within the first 24 hours. The licensee policy titled Vulnerable Adult, dated July 20, 2021, indicated MAARC reports were to be completed within 24 hours whenever an employee discovered abuse or neglect towards residents. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
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. This MN Requirement is not met as evidenced by: The facility failed to ensure three of three residents reviewed (R1, R2, and R3) was free from maltreatment. The findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility 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.	