Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL269776242M **Date Concluded:** February 4, 2026

Name, Address, and County of Licensee Investigated:
Elite Nursing Service
6160 Summit Drive North #560A
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Home Care Provider **Evaluator's Name:** Peggy Boeck, 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 the client when they failed to ensure staff provided home care services (including incontinence cares) which resulted in hospitalization for a kidney infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Documentation indicated a registered nurse assessed the client and created a care plan for unlicensed staff, but the facility had no system in place to ensure staff were aware to begin providing home care services to the client and failed to create and document a schedule to ensure unlicensed staff were available to provide the care required by the client at the client's home. The client reported no staff was available to provide services for four days and the client required hospitalization for a urinary tract/kidney infection.

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

The investigation included review of the resident record, hospital records, facility documentation, personnel files, staff timecards, and related facility policy and procedures.

The client received comprehensive home care services in their home. The client's diagnoses included quadriplegia, insulin dependent diabetes, and pressure ulcers. The client's personal care assistant (PCA) care plan included assistance with bathing, incontinence cares, peri-care, bowel program, skin care, turning, and repositioning. The client was able to make her own decisions and direct her own cares.

Hospital records indicated the client was hospitalized for abdominal pain, a urinary tract infection, overflow diarrhea related to constipation, inflammation of chronic pressure ulcers related to contact with fecal matter, and sepsis.

Client records from the facility indicated a registered nurse assessed the client in a nursing home transitional care unit six weeks before hospitalization and wrote a temporary care plan.

A fax received by the facility licensee 16 days before hospitalization indicated that the client was to be discharged home from a nursing facility. The discharge orders included home care and skilled nursing for wound care.

An e-mail received by the facility licensee sent from the client's case manager nine days before hospitalization indicated the client was approved for in-home care services for 11.5 hours during the day and eight hours overnight. The e-mail indicated the client informed her case manager that the client had no overnight staff since she returned home.

Time sheet documentation received from the licensee indicated two staff recorded hours for providing home care services to the client beginning 15 days prior to hospitalization. Daily totals of 20.5 hours were recorded between the two staff. The facility had no documentation of which staff provided cares for the client on the four days prior to hospitalization.

During an interview, an administrator denied they had been notified of the client's discharge to her home, and did not have documentation of payment, number of hours approved, or services agreed upon from the case manager. The administrator stated two staff they previously employed had new cleared background studies completed, and training provided in anticipation of the client's return to home. The administrator stated they received a call from the client's wound care nurse on the day of hospitalization, who indicated the client told her staff had not shown up for four days, the client had signs and symptoms of a urinary tract infection, and the nurse was calling 911. The administrator stated he did not know how many hours of home care the two staff submitted or were paid. The administrator stated he guessed the client had called the staff when she returned home, which was "wrong and disturbing to me" and the two staff began providing cares without the licensee's knowledge, which was against their policies. The administrator stated the staff were still employed by the licensee.

During an interview another administrative staff stated the case manager provided no information on what services they were to provide until eight days before the client went to the hospital. The administrative staff then confirmed the licensee began providing services when the two staff took it upon themselves to go to the client's home and start providing home cares. The administrative staff stated the licensee stopped providing services to the client four days before she went to the hospital, contrary to the information provided in staff interviews [below].

During an interview, one of the two staff (who submitted hours indicating they provided home care services) provided conflicting information. The staff indicated she worked for the client for many years. Initially, this staff stated she did not know why the client was sent to the hospital and indicated the wound care nurse [who was from another company] called 911. Later in the interview, this staff stated she was at the client's home with the wound care nurse and they both decided to send the client to the hospital. Finally, during the interview, the staff stated she alone sent the client to the hospital and later called the wound nurse.

During an interview, the second staff also provided conflicting information about who provided services and what hours they worked. The second staff stated she provided services for the client on the afternoon shift and some overnights. The second staff stated she worked afternoon shifts the four days prior to the client going to the hospital but later changed her recollection to having split the day shift, working the afternoons, and that the other staff did mornings and overnights. The second staff lastly identified she worked 5 p.m. to 9 p.m. on the four days prior to the client going to the hospital and the other staff worked the remaining 20 hours.

During an interview, the case manager expressed concerns about the accuracy of staff timesheets, lack of licensee oversight of staff, and the relationship between the client and the two staff (who were related).

The client did not respond to requests for an interview.

The wound nurse did not respond to requests for an interview.

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: No, did not respond to request for interview
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken; staff still employed by licensee providing home cares to other clients.

Action taken by the Minnesota Department of Health:
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

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 Center City Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26977	A. BUILDING: _____ B. WING _____	C 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE NURSING SERVICE INC	6160 SUMMIT DRIVE NORTH BROOKLYN CENTER, MN 55430

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, 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: #HL269774880C/#HL269776242M On December 8, 2025, 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 1 clients receiving services under the provider's Comprehensive Home Care Assisted Living license. The following correction order is issued/orders are issued for #HL269774880C/#HL269776242M tag identification _0325, _0865____.	0 000		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act This MN Requirement is not met as evidenced by: The facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. 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.	0 325		
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including	0 865		

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0 865	Continued From page 2 notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff implemented and provided all cares required for one of one client (C1) reviewed for maltreatment. Unlicensed personnel (ULP)-D and ULP-E documented on timecards they provided cares to C1 for 10 days in a row, but the licensee had no documentation or knowledge that the cares were initiated or of who or if cares were provided to C1 for the next four days. C1 required hospitalization for a urinary tract/kidney infection. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1 began receiving home cares from the licensee on July 23, 2025. The client's diagnoses included quadriplegia, insulin dependent diabetes mellitus, and chronic stage four pressure ulcer. C1's care plan dated July 23, 2025, indicated the licensee provided daily personal care assistant (PCA- unlicensed personnel) services including bathing, oral cares, catheter cares, daily bowel	0 865	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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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0 865	Continued From page 3 program, incontinence cares, range of motion, turning and repositioning. C1's medical record indicated registered nurse (RN)-C assessed C1 on July 23, 2025, and determined C1 required home care services, initiated a personal care assistant (PCA) care plan, and had C1 sign the care plan and a statement of home care services. C1's PCA care plan dated and signed by registered nurse (RN)-C and C1 on July 23, 2025, indicated unlicensed staff interventions included the following: shower/sponge bath, catheter care, toileting, incontinence care, bowel program, peri-care, assistance with transfers, and turning/repositioning. C1's nursing home discharge orders dated August 20, 2025, and received by the licensee on August 20, 2025, indicated C1 was homebound and required home care services, including skilled nursing for wound care of a stage four pressure ulcer on her right ischial tuberosity. An e-mail from C1's case manager (CM)-F to the licensee dated August 27, 2025, indicated CM-F approved 11.5 hours of complex PCA services per day and eight hours of overnight. CM-F indicated C1 reported she had not had overnight staff since returning home. [unknown date] Timesheets signed by ULP-D indicated the following days and hours worked with C1: August 22, 2025-12:00 p.m. to 3:00 p.m. August 23, 24, 25, 26, 27, 28, 29, 30, 31, 2025-7:00 a.m. to 2:30 p.m. Timesheets signed by ULP-E indicated the following days and hours worked with C1:	0 865	ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	

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0 865	Continued From page 4 August 23, 2025- 11:00 p.m. to 6:00 a.m. August 26, 27, 28, 29, 30, 31, 2025- 5:00 p.m. to 9:59 p.m. August 24, 25, 26, 27, 28, 29, 30, 31, 2025- 10:00 p.m. to 6:00 a.m. The licensee failed to provide time sheets for ULP-D or ULP-E for dates September 1-5, 2025. C1's hospital records indicated C1 admitted to the hospital on September 5, 2025, at 2:00 p.m. due to symptoms of watery diarrhea and abdominal pain, and concerns of a urinary tract infection. After blood work C1 was diagnosed with a urinary tract infection, constipation with overflow diarrhea, chronic osteomyelitis, and sepsis. The records indicate C1 remained hospitalized for 10 days. During an interview on December 9, 2025, at 1:00 p.m. administrator (ADM)-A stated they were familiar with C1 as they had previously provided home care services for her. ADM-A stated they did not know when C1 was discharged from the nursing home. ADM-A stated C1 requested unlicensed personnel (ULP)-D and ULP-E provide her cares as she knew them for many years. ADM-A stated he did background checks and orientation for ULP-D and ULP-E. ADM-A stated C1 must have called ULP-D when she returned home. ADM-A repeatedly stated he did not know ULP-D and ULP-E were providing cares for C1. ADM-A stated CM-F should have sent them a service agreement including what payment would be. ADM-A acknowledged they received the discharge orders and ULP-D and ULP-E timecards reflected the time they provided cares for C1. ADM-A stated C1's wound care nurse called 911 when they arrived at C1's and reported staff did not show up for the previous	0 865		

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0 865	Continued From page 5 four days. ADM-A stated ULP-D was still employed by the licensee providing home cares for three clients. During an interview on December 10, 2025, at 1:08 p.m. C1's case manager (CM)-F stated C1 had ULP-D as caregiver for 10 years. CM-F stated whenever C1 changed home care provider, C1 would ask for the new provider to hire ULP-D. CM-F stated the licensee completed a background check and provided orientation/training of ULP-D. CM-F stated ULP-D asked the licensee also to hire two of her friends/relatives to care for C1. CM-F stated she had concerns about ULP-D and ULP-E providing cares for C1 related to their relationships with/lack of boundaries with C1 as well as accuracy of time reporting. During an interview on December 11, 2025, at 9:30 a.m., RN-C stated he completed C1's assessment for PCA services. RN-C stated it was not uncommon for home care clients to request PCAs who were known to them. RN-C stated C1's assessment indicated she required turning/repositioning every hour. RN-C stated his job included supervising the unlicensed personnel but was unaware of ULP-D and ULP-E beginning in home services with C1. During an interview on December 11, 2025, at 1:43 p.m. ULP-D stated she worked with C1 for seven or eight years. ULP-D stated she worked day shift and overnights. ULP-D stated ULP-E was her daughter and also worked with C1 on afternoon and overnight shifts. ULP-D stated until the licensee got another staff for C1, she and ULP-D provided all the coverage for C1. ULP-D stated, "What you heard was inaccurate, there was no way she [C1] could be left alone." ULP-D	0 865		

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0 865	Continued From page 6 stated for September 1-5, 2025, she and ULP-E covered all 24 hours with C1. ULP-D initially stated she did not know why C1 was sent to the hospital and indicated the wound care nurse [who was from another company] called 911. Later in the interview ULP-D stated she was at C1's home with the wound care nurse and they both decided to send C1 to the hospital. Finally, during the interview, ULP-D stated she alone sent the client to the hospital and called the wound nurse later. During an interview on December 29, 2025, at 2:30 p.m. ULP-E stated she worked afternoon shift and some overnights. Later in the interview, ULP-E stated she worked day shift and would split overnight shift with ULP-D. ULP-E stated they documented hours and services completed on a paper document that was turned into the office. ULP-E later stated she worked from 5:00 p.m. to 9:00p.m. September 1-4, 2025, and ULP-D worked the other 20 hours. The wound care nurse did not respond to requests for an interview. The client did not respond to requests for an interview. An incident report and investigation regarding staff providing cares without licensee knowledge, lack of staff attendance at C1's home, and hospitalization of C1 was requested but not provided. The licensee's Vulnerable Adult policy dated May 10, 2019, defined a vulnerable adult as a person 18 years of age or older who has a disability that impaired their ability to protect themselves from maltreatment and Neglect as the failure of omission by a caregiver to supply the vulnerable	0 865		

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0 865	Continued From page 7 adult with necessary food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain their physical and mental health and safety. Policies for Nursing Assessments and Documentation of Services were requested but not provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 865		