Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303937382M
Compliance #: HL303932600C

Date Concluded: April 10, 2025

Name, Address, and County of Licensee Investigated:
People Incorporated DSL
726 Northeast Street
Minneapolis, MN 55413
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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), facility staff, abused the resident when the AP verbally threatened the resident, restricted visitors, and hit the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Both the resident and AP denied the allegations.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between residents and staff.

The resident resided in an assisted living facility. The resident's diagnoses included cocaine and alcohol dependence. The resident's service plan included assistance with medication

administration, transportation, appointments, and finances. The resident's assessment indicated the resident had intact cognition and was independent with activities of daily living.

The facility's incident report indicated one day the resident stated he had a friend visiting and asked a staff member to let the AP know "just in case he goes off the course." The incident report indicated the resident was afraid of the AP and the AP had previously hit the resident. The following day, the program supervisor attempted to gather additional information from the resident about the allegation. The resident stated he wanted to "drop it."

During an interview, the program supervisor stated the resident made a vague allegation that the AP hit him. During a follow up interview, the resident dismissed the allegation and did not provide any further details including dates, time, or where he was hit.

During an interview, the AP stated there was no restrictions with the residents having visitors. The AP denied restricting visitors to the resident and denied hitting the resident.

During an interview, leadership stated both the resident, and the AP denied an altercation between the two of them. The AP denied hitting the resident. Leadership stated when the resident was under the influence of alcohol or illicit drugs the resident would make vulgar comments to staff. Leadership stated facility staff thought the resident might have been under the influence when he alleged the AP restricted visitors and hit him. Leadership stated there was no restriction of the resident having visitors.

During an interview, the resident stated he had no concerns with staff and the cares provided by staff including the AP. The resident denied the AP restricted visitors or hit him.

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: …
(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: Yes.

Family/Responsible Party interviewed: No. The resident was responsible for himself.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation.

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
	30393	A. BUILDING: _____ B. WING _____	C 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEOPLE INCORPORATED - DSL	726 NE 2ND STREET MINNEAPOLIS, MN 55413

(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 March 31, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL303937382M/#HL303932600C. No correction orders are issued.	0 000		