DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL35562001M
Compliance #: HL35562002C

Date Concluded: October 7, 2022

Name, Address, and County of Licensee Investigated:
Empire Systems Home Care
6248 Lakeland Avenue, N., Suite 208
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele R. Larson, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 she hit, punched, and twisted the resident's nipples on more than one occasion. In addition, the facility neglected the resident when they failed to bathe and change the resident. The resident smelled from not being bathed and sat in soiled briefs for extended periods of time.

An equal opportunity employer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident reported the same story to his care team and facility staff members. The AP admitted she "poked" the resident. However, facility neglect was not substantiated. The resident reported to a case manager he was happy with the cares he received from the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the AP's personnel record, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury (TBI), paraplegia, blindness, and seizure disorder. The resident's care plan included assistance with personal cares, medication management, eating, meals, toileting, mobility, and transfers. The resident required the assistance of two staff members for all transfers. The resident used a manual wheelchair for mobility. The resident's assessment indicated he was alert and oriented. The resident's vulnerability assessment indicated he was not at risk for self-abuse or to abuse towards others.

Review of the resident's incident report indicated the resident reported to health professionals and facility staff members the AP physically abused him. The report indicated the resident stated the abuse happened more than once. The resident stated the AP pinched his toes, breasts, and poked him on his side, causing the resident pain and to say "ouch, that hurt." The AP laughed at the resident when he told her she hurt him. The AP stated she thought it was "funny," and the resident stated he did not like it, and it hurt. The resident indicated the AP was "heavy handed." The resident indicated he did not alert the facility because he loved living there and did not want to move. The AP was immediately suspended upon the pending investigation.

During an interview, an administrative staff member stated the AP was immediately removed from her job duties once they found out the AP abused the resident. A nurse in the facility expressed concerns about the AP and the facility no longer employed the AP. The administrative staff person stated the AP cried and stated she did not mean to do it, but the facility had to error on the side of the resident. The administrative staff person stated the resident told her the AP touched him inappropriately. The administrative staff person stated there were no further incidents of abuse since the AP stopped working at the facility.

During an interview, the resident stated the AP used to hurt him, stating she squeezed his nipples. The resident stated he told the AP to stop because it hurt, but stated the AP thought it was funny. The resident stated it was not funny and not right, stating he told his family, stating,

“that’s why she doesn’t work here anymore. They fired her because of what she was doing to me.”

During an interview, a family member stated when she found out about the abuse, she contacted the resident who told her it did happen, but stated it happened one time, although the family member stated she could tell by the resident’s body language and facial expressions it was stressful for him. The family member stated at times the resident could be swayed to not be truthful if he felt he was going to lose out on something. The family member stated she told the resident to always speak up for yourself and always speak the truth. The family member stated she believed the resident was safe at the facility.

In conclusion, the Minnesota Department of Health determined abuse by the AP was substantiated. Neglect by the facility was not 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:
(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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

“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:
(a) 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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Numerous attempts to contact the AP were unsuccessful. A subpoena was mailed to the AP, but she never responded.

Action taken by facility:
The facility immediately suspended the AP when they discovered the AP abused the resident. The AP is no longer working at the facility.

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 651-201-4890 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
	35562	A. BUILDING: ____ B. WING ____	C 08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPIRE SYSTEMS HOME CARE	**3301 LAWRENCE ROAD BROOKLYN CENTER, MN 55429**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL35562002C/#HL35562001M On August 18, 2022, 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 clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL35562002C/#HL35562001M, tag identification 510, 630, 1620, 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.
(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. This had the potential to affect all five of five current residents (R1, R4, R5, R6, R7) reviewed.

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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

Findings Include:

COVID-19 VISITOR & STAFF SCREENING
The licensee failed to ensure staff completed COVID-19 screening before the start of their shift.

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0 510	Continued From page 2 The Minnesota Department of Health (MDH) guideline titled, COVID-19 Action Plan for Congregate Settings, updated April 14, 2022, indicated facilities must establish a process to screen all who enter the facility (staff, readmits, contractors, volunteers, visitors) On August 18, 2022, at 10:20 a.m., the state surveyor arrived at the facility and was met by unlicensed personnel (ULP)-A. ULP-A was putting on her face mask when the state surveyor entered the facility. ULP-A took the state surveyor's temperature and had the surveyor sign the visitor COVID-19 symptom sign-in sheet. The state surveyor observed a staff COVID-19 symptom daily sign-in sheet adjacent to the visitor sign-in sheet. The state surveyor observed ULP-A did not fill out the sign-in sheet. On August 18, 2022, at 10:40 a.m., ULP-A stated one ULP worked the following shifts: 7:00 a.m.- 3:00 p.m. (morning) 3:00 p.m.- 11:00 p.m. (evening) 11:00 p.m.-7:00 a.m. (overnight) Review of the August 2022 staff COVID-19 symptom sign-in sheet, indicated between August 1, 2022, and August 18, 2022, staff failed to perform COVID-19 symptom screening on the following dates and shifts: 08.01.2022: Evening, overnight 08.02.2022: Morning, overnight 08.04.2022: Morning, overnight 08.05.2022: Overnight 08.06.2022: Overnight 08.07.2022: No screening completed for all shifts 08.08.2022: Evening, overnight 08.09.2022: overnight 08.10.2022-08.12.2022: No screening completed	0 510		

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for all shifts
08.13.2022: Morning, overnight
08.14.2022: Morning, overnight
08.15.2022: Evening, overnight
08.16.202: Morning, overnight
08.17.2022: No screening completed for all shifts
08.18.2022: Administrative staff.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
The licensee failed to ensure staff wore protective eyewear while in resident care areas or when performing direct resident cares.

The Centers for Disease Control (CDC) COVID Data Tracker, updated weekly, indicated on August 18, 2022, the county transmission level was rated high.

The MDH guideline titled, COVID-19 PPE and Source Control Grids, dated April 7, 2022, indicated direct care staff working with residents without suspected or confirmed SARS-CoV-2 infection wore face masks, and eye protection when working in facilities located in counties with high community transmission levels.

On August 18, 2022, at 10:20 a.m., ULP-A was observed not wearing a face mask or protective eyewear.

On August 18, 2022, at 12:00 p.m., licensed practical nurse (LPN)-C stated she was unaware direct care staff were required to wear eye protection. The state surveyor showed LPN-C the staff COVID-19 symptom screening sign-in sheet showing the dates and times staff never completed the screening. LPN-C stated, " at least they're doing some days."

The license COVID-19 policy, updated June 15,

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0 510	Continued From page 4 2020, indicated the licensee followed MDH and Centers for Disease Control (CDC) infection control recommendations. TIME PERIOD TO CORRECT: Two (2) days.	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure an individualized abuse prevention plan (IAPP) was updated for one of two residents (R1) with records reviewed. R1 was hit and had his nipples twisted by unlicensed personnel (ULP)-F. In addition, the licensee failed to develop and implement an IAPP that included specific measures to be taken to minimize R1's risk of abuse, or specific interventions that addressed R1's verbal aggression towards others. 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	0 630		

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resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

Findings Include:

R1's medical record was reviewed. R1 admitted to the facility on May 8, 2018, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included traumatic brain injury (TBI), paraplegia, blindness, and seizure disorder.

R1's care plan dated May 3, 2022, indicated R1 received assistance with personal cares, eating, meals, medication management, mobility, toileting, transportation, laundry, and housekeeping. R1 required transfer assistance of two staff persons. R1 used a manual wheelchair for mobility.

R1's IAPP dated January 1, 2022, indicated R1 had impaired judgement and required staff supervision 24 hours per day. R1 had difficulty using the telephone due to blindness. Staff were to assist R1 with using the telephone when calling friends or family. R1 was not at risk for abusing other vulnerable adults. R1 had no history of attempted suicide or suicidal thoughts. R1 was not at risk to abusing himself. R1 had a history of physical aggression. Staff were to redirect and encourage R1 to participate in activities when agitated. R1 had a history of non-compliance with house rules when staff redirected R1 to follow house rules. R1 was at risk for falls. Staff were to keep floors clean and dry, and use a two-person total body mechanical lift for all transfers.

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R1's IAPP lacked evidence R1 was assessed for susceptibility to abuse by another individual, including other vulnerable adults, and statements of specific measures to be taken to minimize the risk of abuse to R1. R1's IAPP did not include specific interventions to minimize R1's verbally aggressive behavior.

R1's incident report dated February 16, 2022, indicated R1 told his case manager ULP-F physically abused him on more than one occasion. During the facility investigation, R1 told administrative staff ULP-F pinched his toes, breasts, and poked him on his side that caused R1 to say, "ouch that hurt." R1 stated ULP-F laughed at him when he told her she hurt him. R1 stated ULP-F thought it was "funny," but he stated he did not think it was funny, it hurt, and he did not like it. R1 indicated ULP-F was "heavy handed." R1 stated the abuse occurred more than once. R1 stated the most recent incident occurred February 14, 2022. R1 stated he did not tell staff members because, "I love y'all. I love it here and I am so happy here." During the investigation, administrative staff interviewed another resident who indicated ULP-F would run into R1's room displaying an attitude of wanting to "rip R1's head off," when R1 needed assistance. The resident indicated R1 would not be able to defend himself and stated R1 appeared afraid and his voice would crack when ULP-F was near him. After the investigation, ULP-F was immediately removed from her job duties pending the investigation results.

On August 18, 2022, at 12:30 p.m., R1 stated ULP-F no longer worked at the facility. R1 stated, "she used to hurt me. Squeeze my nipples. I told her it was hurting me. She thought it was funny. It

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0 630	Continued From page 7 is not funny; that is not right at all." R1 stated he told his family about the abuse. R1 stated, "she did it more than once. She woud hit me in my arms too." R1 stated ULP-F no longer worked for the licensee. On August 30, 2022, at 1:35 p.m., licensed practical nurse (LPN)-C stated registered nurses (RN)'s were responsible for creating and updating service plans and IAPPs. LPN-C stated staff were trained not to touch residents inappropriately or cross certain lines. LPN-C stated ULP-F stated she did "poke" R1. LPN-C stated ULP-F was immediately removed from her work duties then terminated a couple of days later. The licensee undated policy titled, Abuse Prevention Plan, indicated all residents admitted to the licensee's facility would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults, and their risk of abusing other vulnerable adults. The facility would develop a statement of specific measures to be taken to minimize the risk of abuse to that person and and other vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 8 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) immediately reassessed one of two residents (R1) with records reviewed upon learning R1 had been physically abused by unlicensed personnel (ULP)-F. The RN waited eight days to reassess R1 after he told staff he was physically abused by ULP-F. This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 9	01620		

R1's medical record was reviewed. R1 admitted to the facility on May 8, 2018, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included traumatic brain injury (TBI), paraplegia, blindness, and seizure disorder.

R1's care plan dated May 3, 2022, indicated R1 received assistance with personal cares, eating, meals, medication management, mobility, toileting, transportation, laundry, and housekeeping. R1 required transfer assistance of two staff persons. R1 used a manual wheelchair for mobility.

R1's incident report dated February 16, 2022, indicated R1 told his case manager ULP-F physically abused him on more than one occasion. During the facility investigation, R1 told administrative staff ULP-F pinched his toes, breasts, and poked him on his side that caused R1 to say, "ouch that hurt." R1 stated ULP-F laughed at him when he told her she hurt him. R1 stated ULP-F thought it was "funny," but he stated he did not think it was funny, it hurt, and he did not like it. R1 indicated ULP-F was "heavy handed." R1 stated the abuse occurred more than once. R1 stated the most recent incident occurred February 14, 2022. R1 stated he did not tell staff members because, "I love y'all. I love it here and I am so happy here." During the investigation, administrative staff interviewed R2 who indicated ULP-F would run into R1's room displaying an attitude of wanting to "rip R1's head off," when R1 needed assistance. R2 indicated R1 would not be able to defend himself and stated R1 appeared afraid and his voice would crack when ULP-F was near him. After the investigation, ULP-F was immediately removed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35562	A. BUILDING: ____ B. WING ____	C 08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPIRE SYSTEMS HOME CARE	**3301 LAWRENCE ROAD BROOKLYN CENTER, MN 55429**

(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
01620	Continued From page 10 from her job duties pending the investigation results. R1's record lacked evidence an RN assessed him after he reported being physically abused by ULP-F. R1's assessment dated February 24, 2022, indicated R1's physical abuse the week before was never mentioned in his assessment. In addition, R1 was never assessed for his susceptibility to being abused by other adults, including vulnerable adults. On August 30, 2022, at 1:35 p.m., licensed practical nurse (LPN)-C (who indicated she was the nurse manager) stated registered nurses (RN)'s were responsible for creating and updating service plans and IAPPs. The licensee undated policy titled, Nursing Assessment and Reassessment of Residents, indicated the RN would reassess each resident on an on-going basis based on changes in the needs of the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
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: Based on observations, interviews, and document review, the facility failed to ensure one of two	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment	

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02360	Continued From page 11 residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On October 7, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	report (report sent separately) for details of this tag.	