Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357497282M
Compliance #: HL357492340C

Date Concluded: January 29, 2025

Name, Address, and County of Licensee Investigated:
Best Home Health Care
6044 Clinton Avenue
Minneapolis, MN 55419
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
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 they failed to provide supervision. As a result, the resident attempted self-harm. Additionally, the facility neglected the resident when they failed to provide food according to the resident's dietary guidelines.

Alleged perpetrator (AP #1) emotionally abused the resident when she made disparaging comments about the resident's case workers and the financial penalties the AP received because of the resident.

Alleged perpetrator (AP #2) abused the resident when they physically grabbed the resident's writs and took her to the table to eat. As a result, the resident did not feel safe living at the facility.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident burned her wrist with a cigarette, the staff members were unaware the incident occurred because the resident did not tell them until one week later. Additionally, the resident restricted the facility's ability to communicate with her medical providers which limited the facility's ability to develop an accurate plan of care to manage the resident's nutritional, medical, and mental health diagnoses.

The Minnesota Department of Health determined emotional abuse was not substantiated. AP #1, who was an owner, managed the facility's operational costs and worked with the resident regarding financial issues such as the resident's rent, medical supplies, and internet services. AP #1 did not restrict the resident's case workers from the facility. Although communication between the resident and AP #1 was unprofessional, it did not meet the statute requirement for abuse.

The Minnesota Department of Health determined physical abuse was not substantiated. Video footage indicated AP #2, an unlicensed personnel (ULP), did not grab the resident's wrist and take her to the table.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers. The investigation included review of the resident medical records, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed the dining areas, food supply, menu, medication storage, video footage, and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, depression, anxiety, and an eating disorder. The resident's service plan included assistance with bathing, dressing, medications, and behavior management. The resident's nursing assessment indicated the resident had vision loss and was legally blind. The nursing assessment indicated the resident was able to communicate her needs and her memory was intact. The resident had a history of self-harm attempts, agitation, and aggression.

The resident's medical record contained a letter she wrote to the facility. The note indicated the resident refused to allow the facility access to her medical records and/or communication with her physicians. The letter indicated the resident understood her refusal could impact the services provided by the facility. The letter indicated the resident informed her case manager, and ombudsman (resident advocate) about her decision and she would take legal action against the facility if they attempted to do so.

The resident's medical record (at the facility) lacked required content about the resident including diagnoses. It was unknown if the facility interventions for behavior and medical management were appropriate because the resident's diagnoses were inaccurate and/or not identified. The resident's medical record lacked a diagnosis of dissociative identity disorder, and subsequent nursing assessments lacked interventions for management of dissociative identity

disorder. The resident's record contained a customized living rate worksheet, commonly known as the 6790. The 6790 indicated the resident had a diagnosis of paranoid schizophrenia, however no other documentation supported this diagnosis to be correct. The 6790 also lacked a diagnosis of dissociative identity disorder. The resident's admission face sheet provided to the facility by the resident's case manager, lacked a diagnosis of dissociative identity disorder and paranoid schizophrenia.

During an interview, a case manager said she coordinated the resident's admission into the facility. The case manager said the resident had dissociative identity disorder (multiple personality disorder). The case manager said she told the facility the resident required various items for the resident's alternate identity, who was a child. The case manager said she was not positive if the facility received all the resident's medical and mental health diagnoses. The case manager said the facility did not request documentation, while other facilities did, however she also did not proactively provide them. The case manager said she was unaware of the regulatory requirements for licensed assisted living facilities.

Facility Neglect Allegation, **Self- Harm:**
During an interview, the resident said she became upset and acted impulsively and burned her wrist with a cigarette. The resident said she did not tell anyone for fear of having to go to the hospital. The resident said the incident was a coping mechanism, not a suicide attempt. The resident told the nurse about the incident a week later when the nurse could not do anything further about it. The resident said she struggled with impulse control regarding self-harm. The resident said self-harm occurred twice while she lived at the facility, however prior to admission into the facility, she hurt herself every day by cutting and burning. The resident said at the time of the incident she was in "turmoil" because AP #1 made her feel worthless during their communication. The resident said AP #1 crossed professional boundaries by allowing them to refer to each other as "mother" and "daughter." The resident said she allowed AP #1 to use those words, but then AP #1 told the resident she was not her daughter, and this was what caused the resident to become upset.

During an interview, the nurse said AP #1 and the resident got into an argument and she went to the facility to talk with the resident. The nurse said the resident showed her burn marks on her wrist. The nurse said she observed small scab areas to the resident's wrist, however the injury did not require further medical care. The nurse said the resident told her AP #1 "hurt" her. The nurse said the communication between the resident and AP #1 consisted of text messages about hurt feelings, and she did not understand the context of the messages. The nurse said the resident and AP #1 got comfortable calling each other "sweet names," like "mother" and "daughter." The nurse said and she could not determine what occurred. The nurse said the resident did not allow her to contact her medical providers, which made it difficult for her to do her job and comply with regulatory requirements.

Clinic medical records obtained during this investigation lacked a diagnosis of paranoid schizophrenia. Medical records indicated the resident attended a medical appointment six days

prior to burning herself with a cigarette. The medical records indicated the resident told the physician she self-harmed a few times and thought about suicide daily.

Facility Neglect Allegation, Food:
During an interview, the resident said she had an eating disorder and had a gastric (stomach) tube. The resident said she ate food items orally; however, the facility did not comply with her dietary guidelines which caused her stomach distress. She then required a puree diet (soft, blended food texture).

During an interview, a nurse said the resident received her medications through the stomach tube, but she took food orally. The nurse said the resident changed her diet often, but did not always give the facility a physician's order. The nurse said the resident currently received a puree diet; however, the resident was not compliant with the diet. The nurse said the resident gave the facility a list of food items she wanted to eat, then they created the weekly menu.

A physician from a specialty clinic ordered a puree diet for the resident. The date on the order was after the allegation occurred. It is unclear when the resident provided the facility this order.

The resident's care plan indicated she required a regular diet with regular (thin) liquids. The care plan was in place prior to the physician order for a puree diet. The care plan indicated the resident ate well and was not a "picky" eater.

Progress notes indicated a month prior to the puree diet order, the resident ate food items such as pizza, subway sandwiches, sausage, eggs, hashbrowns, fish, fruit, apple pie, tacos, and spaghetti. Progress notes indicated the facility asked the resident multiple times to assist with menu preparation. Progress notes indicated one day before the physician ordered a puree diet, the resident ate a 12-inch subway sandwich for lunch. Progress notes indicated the resident ate smoothies, shakes, soup, and crackers after the physician ordered a puree diet. Progress notes indicated the facility staff members prepared food for the resident, but the resident was not always accepting of food. Progress notes indicated the resident also prepared her own food.

Emotional Abuse Allegation AP # 1:
During an interview, the resident said AP #1 "flip flopped" the boundaries (mother/daughter) and emotionally hurt her when the resident's case worker helped the resident cook. The resident said AP #1 did not like the case worker because the case worker "invaded her territory. " The resident said everything just "spiraled" from there. The resident said she was talking to a friend on the phone, and AP #1 called the resident to the living room. She had her friend on the phone because she wanted a third-party present. AP #1 took the phone from her and hung it up.

During an interview, AP #1 said she communicated with the resident through email and text. AP #1 said the resident sent her multiple emails about various things, even things they resolved. AP #1 said the resident called her "mommy" and AP #2 (AP #1's husband) "daddy." AP #1 said

she had a conversation with the resident about ground beef and after the conversation, the resident left the kitchen. The resident brought her phone to AP #1 and said her case worker wanted to talk with her. The case worker accused AP #1 of stealing the food from the resident and told her she was going to “report her.” AP #1 said she hung up on the case worker after the accusation, but the resident internalized their conflict. AP #1 said she did not place restrictions on the case worker’s ability to come to the facility. AP #1 said the resident was angry with her after this occurred. AP #1 said she had multiple conversations with the resident regarding money because the resident mismanaged her finances and was unable to pay her rent or medical bills. AP #1 said there were also financial issues regarding the internet service because the resident opened an account with AP #1’s name on it, then threatened to “report” AP #1 to an ombudsman (resident advocate).

During an interview, a support worker from an outside agency said she takes the resident out into the community for various activities. The support worker said she was unaware of the resident’s medical or mental health diagnoses. The support worker said she had knowledge about some aspects of the resident’s health from what the resident told her. The support worker said the resident called her after she left the facility. She was crying and told her AP #1 was “yelling” at her about the how much ground beef she used for cooking. The support worker said she spoke to AP #1 and asked what occurred, however AP #1 was defensive. The support worker said she then stopped talking to AP #1 but could hear conversation in the background before she hung up the phone. The support worker said she heard the AP #1 tell the resident she did not need to call others and get them involved. The support worker said she did not have any further conversations with AP #1 after this incident occurred. The support worker said it was her manager who told her not to go into the facility because there have been allegations from the facility, against the support worker regarding missing items. The support worker said when she enters the house, AP #1 and AP #2 leave out the back door, however the support worker leaves the facility with the resident for community outings.

The resident wrote multiple, lengthy emails to AP #1 regarding emotional pain, but the source of the pain was unclear. Email communication indicated the resident had a close relationship with AP #1 and described her as being kind, compassionate, and loving. The resident wrote in emails she felt loved when AP #1 called her “daughter” and “princess”, and she “clung” to those words. The resident’s emails indicated AP #1 made her feel as though she mattered and was part of the family. One of the resident’s emails to AP #1 indicated the AP hurt her “beyond repair” and she was “pissed.” AP #1 responded to the email and addressed the resident as, “My Dearest Princess.” AP #1’s response indicated she never imagined something like this would come between them, especially between, “a mother and daughter.” AP #1 apologized to the resident for the pain both experienced. AP #1 asked the resident for “forgiveness.” AP #1’s email indicated she cared for the resident and wanted to heal their rift. The resident continued to send AP #1 emails including poetry, and songs. AP #1 wrote an email to the resident indicating she required the resident to give her space. AP #1 wrote in the email she did not want the resident to harm herself and did not want her to lose her support workers because they cared for and respected her.

Abuse Allegation AP #2:
During an interview, the resident said AP #2 grabbed her by the wrist and took her to the table. The resident said AP #2 was the only staff member who did this to her. The resident said AP #2 laughed when the resident confronted him and said he was just joking. The resident said she did not get injured.

During an interview, AP #2 said he never grabbed the resident's wrists. AP #2 said the resident only allowed AP #2 to help her with her personal cares because they had a good relationship.

The resident sent the surveyor a message indicating this behavior occurred again after the surveyor left the facility. The facility's electronic monitoring system recorded images when the system recognized movement. The facility kept images for thirty days (per AP #1). Video footage during mealtimes indicated the resident walked independently to and from the dining room table. Video footage did not show AP #2 touch the resident at any time. Audio footage indicated AP #2 talked with the resident and the two engaged in pleasant conversation. Video footage was unavailable when the initial allegation occurred.

At the time of this investigation, the facility was not in compliance with regulatory requirements for their assisted living licensure and correction orders were previously issued by a different surveyor. The facility was in the process of making the required corrections during this investigation, therefore, no further correction orders were issued.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

The Minnesota Department of Health determined emotional abuse was not substantiated.

The Minnesota Department of Health determined physical 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:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;

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.
Family/Responsible Party interviewed: No. Not Applicable.
Alleged Perpetrator interviewed: Yes, AP #1 and AP #2.

Action taken by facility:
The facility coordinated meeting with the resident’s case manage and support workers.

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
	35749	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST HOME HEALTH CARE SERVICE	6044 CLINTON AVENUE SOUTH MINNEAPOLIS, MN 55419

(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 December 20, 2024, the Minnesota Department of Health initiated an investigation of complaint HL357492340C/HL357497282M. No correction orders are issued.	0 000		