Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36654001M
Compliance #: HL36654002C

Date Concluded: September 27, 2022

Name, Address, and County of Licensee Investigated:
Heart of a Star Home Care
6430 Toledo Ave N
Minneapolis, MN 55429

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, facility and 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 facility and alleged perpetrators (AP) emotionally abused a resident when they used inappropriate language and conduct during interactions with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was substantiated. The facility and alleged perpetrators (AP#1 and AP#2) were responsible for the maltreatment. The facility did not allow privacy when questioning the resident regarding behavior issues and did not intervene when management and a staff member demonstrated inappropriate behavior when communicating with the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker and a family member. The investigation included review of resident records, facility policies and procedures regarding abuse prevention, staff training and competency evaluations. In addition, the investigator reviewed cell phone audio and video of the incidents.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, memory deficit, post-traumatic stress disorder (PTSD), and major depressive disorder. The resident's service plan included assistance with behavior management for anxiety, verbal aggression, delusions, depression, and paranoia. The resident's assessments indicated the resident was at risk for abuse due to mental illness. The resident's vulnerabilities were listed as anxiety that was increased when there were a lot of people around, depression that would cause him to self-isolate, have loss of sleep, loss of appetite, and paranoia.

One evening, AP#1 called the resident to a meeting to address his behavior. This meeting also included two additional residents and AP#2. The resident felt uncomfortable with the situation and recorded the event on his cell phone. During the meeting numerous accusations and questions were directed at the resident with multiple people talking at him at one time. The resident was uncomfortable with the confrontation however, unable to retreat to his bedroom because the door was locked, and his key was in the room. Additionally, two days prior to this meeting, the resident and AP#2 had an encounter where AP#2 used inappropriate language and behavior with the resident.

Review of a video of the incident involving AP#2 included AP#2 saying something to the resident and the resident answering with profanity. AP#2 replied by yelling and exchanging further profanity with the resident. AP#2 then walked toward the resident and challenged him to respond to her behavior. The resident declined.

Review of audio and video of the group meeting indicated the following:

AP#1 accused the resident of theft and not treating other residents with respect. AP#1 threatened to tell another resident, who was present at the meeting, what the resident said about him. AP#1 indicated that this resident was then going to "slap him [the resident] straight". AP#1 confronted the resident regarding money he had loaned him and told him it had been a test to see if he was responsible enough to pay it back and he had failed. AP#1 further threatened the resident that if he did not move out the next day, he was going to throw the resident and his belongings out in the snow. Throughout the meeting AP#1, AP#2, and the two other residents were yelling and talking at the resident at the same time. The resident reminded AP#1 about his mental health issues and that the interaction was putting his "head in a bad place". The resident asked AP#1 multiple times not to touch him and not to stand over him. AP#1 did not comply. In addition, several times during the meeting the resident requested AP#1 to question him in privacy and not in front of everyone. AP#1 did not respond to the request.

During an interview, AP#1 stated he tried to have a discussion with the resident because he threatened to slap another resident, had insulted people, and was fighting with people. AP#1 stated he had a group meeting to restore harmony to the house. AP#1 stated at no time did he yell at the resident or put his hands on the resident.

During an interview, the AP#2 stated she approached the resident about complaints from other residents that he was taking items from their rooms. AP#2 indicated the resident went to the other resident's doors and yelled at them. AP#2 stated the resident later apologized for his behavior. AP#2 denied that she yelled or used inappropriate language towards the resident.

During an interview, unlicensed personnel (ULP)#3 stated she witnessed the confrontation between the resident and AP#2. ULP#3 stated AP#2 scolded the resident for taking money from ULP#3's purse. When asked if AP#2's language and behavior was appropriate with the resident, ULP#3 stated "no", however she did not intervene because she was upset about the money missing from her purse.

During an interview, the resident stated the day before he moved out of the facility AP#1 called a meeting. When the resident came out of his room a staff member locked the door behind him so he could not re-enter. The resident stated AP#1 grabbed him by the arm and squeezed it, play fighting with him. The resident stated he repeatedly told AP#2 to get his hands off of him but he kept grabbing him and he felt violated. The resident stated AP#1, AP#2, and two other residents were gathered in the common area of the facility during this meeting. The resident stated everyone in the room was talking to him at once and he felt like he was under attack and bombarded by the group. The resident stated this went on for about a half an hour and then AP#1 left the house. The resident stated the remaining group continued with their behavior and AP#2 got in his face pointing her finger and yelling at him. The resident stated that after this incident he needed to call a mental health crisis hotline a couple of times because the incident put his "head in a bad place".

In an email sent to the investigator, the resident indicated that after AP#1 put his hands on him he had flashbacks of childhood abuse and that he felt unsafe, endangered, overwhelmed, threatened, and fearful.

In conclusion, the Minnesota Department of Health determined emotional abuse 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.

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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action was taken by facility. The resident transferred to another facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36654	A. BUILDING: _____ B. WING _____	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART OF A STAR HOMECARE	6430 TOLEDO AVENUE NORTH 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
0 000	Initial Comments Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #HL36654002C/#HL36654001M On August 4, 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 four residents receiving	0 000	No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.	

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0 000	Continued From page 1 services under the provider's Comprehensive Assisted Living license. The following correction order is issued for #HL36654002C/#HL36654001M, tag identification 2360	0 000		
02360 SS=G	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 five residents (R1) was free from maltreatment when R1 was emotionally abused. Findings include: On August 4, 2022 the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility and individual staff were 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		