

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL368807944M  
**Compliance #:** HL368804887C

**Date Concluded:** November 20, 2023

## **Name, Address, and County of Licensee**

### **Investigated:**

Hope Residential Homes LLC  
4008 129<sup>th</sup> Street  
Savage, Minnesota 55378  
Scott County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Holly German, 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 the facility failed to properly supervise the resident, which resulted in the resident causing physical harm to himself.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The resident was under psychiatric care, and the facility provided adequate supervision per the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff and a family member. The investigator contacted law enforcement. The investigation included review of the resident's medical records, facility investigation report, police report and staff schedules. Also, the investigator toured the facility and observed staff interactions with the residents.

The resident resided in an assisted living facility. The resident's diagnoses included paranoia, delusional disorder, schizophrenia, and back pain. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was alert and oriented to person, place, time and was independent with all activities of daily living with reminders. The resident lived at the facility for two years. The resident did not have any self-harm behaviors prior to the incident.

Hospital records indicated the resident had a psychiatric evaluation and was prescribed a new medication that was used for bipolar disorder one week prior to stabbing himself. The resident's medication administration record (MAR) indicated the resident had multiple medication order changes and the resident took his medications as ordered.

On the morning of the incident, the resident used a knife he had in his room to stab himself in the chest resulting in a hospital stay and a superficial wound.

The law enforcement report indicated the resident was noted on the floor in the living room with a blood-soaked towel held to his chest. Law enforcement officers stated the resident told them he heard voices telling him to kill himself. Law enforcement noted a cut to the resident's left chest, then one inch in length. Law enforcement located a bloody knife on the second floor in the resident's bedroom. Law Enforcement report indicated officers commended the staff on site for their quick thinking of applying pressure to the wound.

During an interview, the resident stated he stabbed himself without thinking about it. He stated he did not tell staff he was having self-harm thoughts, or that he was going to do it. The resident stated his needs were met at the facility and he felt safe.

During an interview, the registered nurse (RN) stated she was not aware of the resident having any previous history of self-harm, and the resident had always denied wanting to harm himself during the performed assessments. The RN stated they were aware of his reported voices heard in his head, but the voices did not reveal to be demanding. They were described as chatter that kept him up at night. The RN had brought the resident to the hospital a week before the incident for mental health concerns and the resident was discharged back to the facility the same day.

During an interview, an unlicensed personnel (ULP) stated he had noted the resident to be laying awake in his bed at eight o'clock in the morning when he checked on him the day of the incident. The ULP stated the resident said he was fine when asked how he was doing. The ULP stated he did not see the resident again until he came downstairs to the living room about an hour later, wearing a shirt covered in blood. The ULP stated he grabbed a towel to put pressure on the wound, notified emergency medical services via phone, then notified the RN via phone. The ULP stated the resident did not exhibit any signs or symptoms of self-harm ideation prior to the incident.

During investigative interviews, multiple staff members stated they were not aware of any previous incidents of the resident harming himself while at the facility or prior to moving into the facility. Multiple staff stated they provided one to one supervision of the resident upon his return from the hospital.

During an interview, a family member stated he felt the resident's needs were met at the facility, and he was safe at the facility. He stated he felt the facility is doing all they can for the resident.

In conclusion, the Minnesota Department of Health determined neglect 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.

**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:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility staff rendered first aid and called emergency medical services immediately.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36880</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/08/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HOPE RESIDENTIAL HOMES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4008 129TH STREET SAVAGE, MN 55378</b>
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(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	<p><b>Initial Comments</b></p> <p>On November 8, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL368804887C/#HL368807944M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_