Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369996904M
Compliance #: HL369991379C

Date Concluded: March 24, 2025

Name, Address, and County of Licensee Investigated:
Risen Home Care LLC
5333 James Avenue North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Inconclusive

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), a facility nurse, abused the resident when the AP grabbed the resident's arm in retaliation and threw water on him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Conflicting accounts of the incident were provided and the AP denied abusing the resident. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, as well as hospital staff, and case managers. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The investigator toured the facility, including the resident's room, as well as observed staff interactions and care provided by facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included obsessive compulsive disorder, intellectual disability, and ischemic heart disease. The resident's service plan included medication administration, laundry, housekeeping, meal reminders, and safety checks. The resident's assessment indicated the resident was independent with most activities of daily living and staff were to provide reminders and cues when needed.

A review of complaint documents indicated that on the evening of the incident, the AP asked the resident to exit the common television viewing area. The resident refused and a verbal altercation began which led to the resident retrieving a cup of water from a nearby bathroom and throwing it at the AP. The AP then grabbed the resident by the arm, leaving a bruise on the resident. Days later, the resident was transported to a local hospital with complaints of left arm pain and had bruising of unknown origin was noted on her arm.

There was no witness to the incident and no documentation to indicate the AP grabbed the resident's arm at the time the incident occurred. Facility documentation did not indicate concerns of bruising noted on the resident's arm. The resident was transported to the hospital days after the incident occurred due to concerns over a surgical site on the opposite forearm.

During an interview, the AP, a facility nurse, stated while providing care to other residents, the residents complained about the afterhours television volume and loud voices coming from the common area on the first floor. Due to the complaints by other residents, the AP then told the resident to continue watching television downstairs in her own room. The resident then grabbed a cup of water and poured it on the AP before leaving the area and going downstairs. The AP denied retaliating or grabbing the resident in anyway. After the incident occurred, the AP notified an administrator and once he had completed his assigned tasks, he left the facility.

During an interview, the resident recalled the AP entered the common room around midnight and turned off the T.V. The resident stated, "I was mad, so I got a glass of water and throwed it, I throwed it at him", and then [the AP] got mad at me and grabbed my arm. The resident was not able to recall further details surrounding the incident and did not recall the later admission to the hospital.

During an interview, a guardian stated that he was made aware of the incident by the facility. The guardian recalled that days after the incident occurred, he observed a bruise on the resident's arm, which he described it as a single bruise and due to its size, shape, and location, questioned if it was self-inflicted by the resident.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

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

Action taken by facility:
The facility completed an internal investigation into the incident and the AP received re-education.

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 651-201-4200 to receive a copy via mail or email.

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
	36999	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN HOME CARE LLC	5333 JAMES AVENUE BROOKLYN CENTER, MN 55430

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL369991379C/#HL369996904M On February 27, 2025, 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 services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL369991379C/#HL369996904M, tag identification 0620.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State 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.	

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0 620	Continued From page 1	0 620		
0 620 SS=F	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 2 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and implement a written procedure to ensure all cases of suspected maltreatment were reported. In addition, the licensee failed to report an incident of suspected abuse to the Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for one of one resident (R1). 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	0 620		

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0 620	Continued From page 3 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: R1's diagnoses included diagnoses included obsessive compulsive disorder, intellectual disability and ischemic heart disease. R1's uniform assessment dated December 16, 2024, indicated R1 received services to include medication administration, laundry, housekeeping, meal reminders and safety checks. R1 was independent with most activities of daily living although staff were to provide reminders and cues when needed. Review of a facility incident report dated November 5, 2024, under the heading #6 Description of Grievance/Complaint: I indicated a verbal altercation began between the alleged perpetrator (AP) and R1 which led to R1 retrieving a cup of water and throwing it at the AP. The same report under heading #9 Was MAARC report done (copy attached/ Within 24 hours) was left blank. Review of a facility incident report dated November 18, 2024, under the heading #6 Description of Grievance/Complaint: I indicated LALD-A received a call from the guardian stating that R1 had called to report a bruise on her arm that was done by the AP. The report under heading #9 Was MAARC report done (copy attached/ Within 24 hours) indicated, No. Review of complaint documentation indicated the estimated date and time of the incident was on November 4, 2024. A Minnesota adult abuse	0 620		

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0 620	Continued From page 4 reporting center report was not filed by the licensee until January 10, 2025. During an interview, Licensed Assisted Living Director (LALD)-A stated that the delay in reporting was a "mistake on my part, I should have sent it right away". The licensee's maltreatment reporting policy was requested. LALD-A provided a copy of a policy titled, Incident Reporting Policy, Minnesota Comprehensive Home Care Manual REF. MN Statutes 144A.4791, Subd. 9, 11, 13. The licensee held a current Assisted Living Facility (ALF) licensure and the policy was not reflective of the licensee's licensure requirements. The licensee lacked policies to include the Assisted Living Licensure requirements MN Statutes 144G, which came into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		