Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL391377722M
Compliance #: HL391373240C

Date Concluded: March 31, 2025

Name, Address, and County of Licensee Investigated:
Epiphany Care Homes LLC
4441 Hunters Ridge Road
Minnetonka, Minnesota 55345
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 alleged perpetrator (AP) abused the resident when the AP grabbed the resident's wrists and later pushed her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP's conduct during the interaction could not reasonably be expected to produce physical pain or injury. Additionally, the AP only temporarily held resident 1's wrists while the resident had been physically aggressive towards her when near resident 2.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and resident 1's case manager. The investigation included review of the resident records, facility incident report, personnel files, staff schedules, law enforcement report, and related facility policies and procedures. Also, the investigator observed safety and how staff interacted with the residents.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included several mental health diagnoses and diabetes. Resident 1's service plan included assistance with safety checks and medication management. Resident 1's assessment indicated resident 1 displayed repetitive or obsessive behaviors, anxious, paranoid, or suspicious behaviors. The assessment indicated resident 1 also displayed deficits in judgement, did not respond well to prompts and cueing, and exhibited inappropriate behavior such as wandering aimlessly, showing anger, provocation, verbal abuse, or other extreme or erratic behavior patterns.

Resident 1's individual abuse prevention plan (IAPP) identified the resident as at risk of abusing other vulnerable adults and self-abuse. Interventions in place included monitoring resident 1's behavior and intervene.

A progress note indicated resident 1 hit and pushed staff after being redirected out of the kitchen while another resident prepared food as an activity. Resident 1 provided no reason for the incident.

A facility incident report indicated resident 1 had been standing near the stove while resident 2 made a meal. The AP instructed resident 1 to move away from the stovetop and placed her hands on resident 1's shoulders to redirect her away from the hot stove. Resident 1 responded to the AP by physically attacking the AP and pushing her back, causing the AP to be backed up near the sink. Staff did not observe any injuries after the incident. Facility staff contacted resident 1's family, case managers, and provider. The incident report indicated resident 1 had a history of agitation with the AP and problematic behaviors in the kitchen.

Video footage of the incident showed resident 1 enter the kitchen while resident 2 stood at the stove and the AP monitored from the table. The AP noticed resident 1 and said something to her. Resident 1 looked over at the AP then began walking toward the stove and resident 2. The AP got up and walked over to resident 1, again appearing to speak to her. At this point, the AP stayed several feet away from resident 1. Resident 1 walked closer to the stove until she stood next to resident 2. The AP approached resident 1, placed her hands on resident 1's shoulders, and attempted to guide her out of the kitchen. Resident 1 began hitting, grabbing and pushing the AP backwards. The AP held resident 1's forearms and wrists while speaking to resident 1. Resident 1's hands remained fisted while she continued pushing the AP backwards. The AP released resident 1, one wrist at a time, as resident 1 turned away from the stove. The AP placed one hand on resident 1's back and one hand on her arm, appearing to guide her out of the kitchen. When the AP took her hand off resident 1's back, resident 1 did not appear to lose balance, stumble, or fall forward. Resident 1 stopped, turned, and looked back at the AP.

During an interview, resident 1 stated she did not remember much of the incident but thought the AP may have pushed her. Overall, resident 1 liked living at the facility and had no safety concerns.

During an interview, resident 2 stated she had been completing her weekly activity of prepping and making dinner. Resident 2 had previously asked staff to keep other residents out of the kitchen during this time, so no one got hurt and she could complete her task. Resident 1 had an issue with food and would go through the refrigerator and want to be near the food. The evening of the incident, resident 1 walked into the kitchen and wanted to know what was being made for dinner. Resident 1 came toward resident 2, coming between resident 2 and the stove where she worked. The AP instructed resident 1 to leave the kitchen. Resident 1 pushed the AP, and they got into an argument when the AP tried getting resident 1 away from the stove. Resident 2 stated she did not think the AP pushed resident 1. Resident 2 stated the AP enforced the rule that the other residents were not supposed to be in the kitchen while resident 2 prepared dinner, and the AP had done the right thing during the incident. The AP made sure resident 2 did not get burned during the incident.

During an interview, the licensed assisted living director (LALD) stated resident 1 displayed food aggression and could be verbally and physically aggressive. Resident 1 went into the refrigerator and cupboards to eat inappropriate items like hot sauce. Due to her psychiatric medication, resident 1 never felt satiated. Additionally, resident 1 had no regard for safety and would try putting her hand into whatever was being cooked. Regarding the incident, the LALD stated she thought it was okay for the AP to put a hand on resident 1's back. The AP also tried to pivot resident 1, which facility staff did a lot. After the incident, the facility completed re-education with staff about resident 1 and about keeping residents safe. They have been trying to come up with ways to keep resident 1 out of the kitchen, but they do not think anything will stop her from coming in when instructed to stay out.

During an interview, a nurse stated resident 1 had a history of coming into the kitchen when instructed to stay out. Resident 1 repetitively came into the kitchen and would grab food out of a burning pot. The nurse stated they held education with the AP and all staff about resident 1's behavior and what to do in that situation.

During an interview, the AP stated resident 1 constantly came into the kitchen to eat. Resident 2 made dinner once a week, and often told staff to make sure they kept resident 1 out of the kitchen. Resident 1 would try putting her hand into food to eat it, even if it was being heated on the stove. The day of the incident, resident 1 came into the kitchen. The AP told resident 1 she did not need to be in the kitchen. The AP saw resident 1 walking toward the back (near the stove) and felt concerned for her safety. The AP told resident 1 she was not supposed to be there. Resident 1 became angry and hit the AP. The AP held resident 1's wrists and told her to stop hitting. After resident 1's temper improved, she stopped holding her wrists. When resident 1 left the kitchen, the AP immediately called the nurse and reported the incident. The AP denied hitting resident 1. The AP stated she also made sure to protect resident 2 during the incident.

In conclusion, the Minnesota Department of Health determined 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:
(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: No. Attempted, but did not reach for interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reviewed video footage and talked with the AP and residents. The facility completed education with staff about the resident.

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
	39137	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY CARE HOMES LLC	4441 HUNTERS RIDGE ROAD MINNETONKA, MN 55345

(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 March 17, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL391373240C/#HL391377722M. No correction orders are issued.	0 000		