Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392343426M
Compliance #: HL392342750C

Date Concluded: July 30, 2026

Name, Address, and County of Licensee Investigated:

Diversity Home Care
3853 Kings Wood Court 2
Eagan, MN 55122
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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) abused resident #1 when she instructed staff to sign out resident #2's quetiapine (an atypical antipsychotic medication with an off-label use to manage agitation) and administer it to resident #1 as a form of chemical restraint to manage his agitation.

The alleged perpetrator (AP) financially exploited resident #2 when she ordered staff to sign out his quetiapine and document that it was administered to resident #2, while actually administering the medication to resident #1, who did not have an order for quetiapine.

The alleged perpetrator (AP) neglected resident #2 when failed to adhere to acceptable standards of infection control after resident #2 was diagnosed with *Clostridioides difficile (C. diff*, a contagious bacterium that infects the colon causing diarrhea, fever, and abdominal pain).

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. Accounts differed as to whether staff administered resident #2's quetiapine to resident #1. Resident #2's medication administration record (MAR) indicated his quetiapine was administered to him as prescribed. Resident #1's MAR indicated he had prescriptions, including quetiapine, to help him manage agitation.

The Minnesota Department of Health determined financial exploitation was inconclusive. Accounts differed as to whether resident #2's quetiapine was diverted to resident #1. Resident #2's medication administration record (MAR) indicated his quetiapine was administered to him as prescribed. Resident #1's MAR indicated he had two prescriptions of his own, including quetiapine, to help him manage agitation.

The Minnesota Department of Health determined neglect was not substantiated. At the time of observation, resident #2 was living in a private room, appropriate personal protective equipment (PPE) was available for staff, and staff wore appropriate PPE when providing cares to resident #2.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident records, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff providing cares to residents and observing infection control practices.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included general muscle weakness, moderate intellectual disabilities, traumatic brain hemorrhage, impulsiveness, major depressive disorder with psychotic symptoms, and obesity. Resident #1's services included assistance with activities of daily living, meals, medications, and behavior management. Resident #1's assessment indicated he required full assistance with activities of daily living.

Resident #2 resided in a private room in an assisted living facility. Resident #2's diagnoses included stroke, muscle weakness, and difficulty swallowing. Resident #2's services included assistance with activities of daily living, meals, and medications. Resident #2's assessment indicated he required full assistance with activities of daily living. Resident #2 was receiving hospice services.

MEDICATION MANAGEMENT

Resident #1's MAR indicated he was prescribed divalproex (anti-seizure medication for off-label mood management) and risperidone (anti-psychotic) to manage "mood disorder," diazepam (anti-anxiety) to manage anxiety, and quetiapine prescribed as needed to manage agitation.

Resident #2's MAR indicated he was prescribed oral quetiapine twice a day. Staff documented administering the quetiapine to resident #2 as prescribed. Resident #2's quetiapine was held during his hospitalizations.

Resident #1's progress notes indicated he alternated between "good" days when he was in good spirits, and some days where he was agitated and difficult to redirect. Conferences with family were documented, as well as requests to resident #1's prescriber to adjust resident #1's medication regimen attempting to better manage agitation.

INFECTION CONTROL

Resident #2's progress notes indicated he did well until the middle of the month when he developed a high fever, vomiting, and a slight cough. Resident #2 was hospitalized, and tested negative for influenza and COVID. The resident returned from the hospital after nine days but went back to the hospital two days later when he started to have difficulty swallowing. It was documented that resident #2's family wanted a gastric (G)-tube (a medical device inserted directly into the stomach through the abdominal wall) placed. Resident #2 returned from the hospital after 11 days, with no G-tube placed. A conference with family and hospice was held to discuss comfort cares.

Resident #2's hospital records indicated he was hospitalized for nine days and diagnosed with bacterial pneumonia. Resident #2 was treated with intravenous (IV) antibiotics for pneumonia, and then developed *Clostridioides difficile* (*C. diff*, a contagious bacterium that infects the colon causing diarrhea, fever, and abdominal pain) because of the antibiotic treatment. The resident returned to the facility on an oral antibiotic to treat the *C. diff*. Resident #2 returned to the hospital two days later due to weakness, confusion, and not eating, drinking, or taking medications. Family considered the placement of a G-tube, but eventually decided against it. Resident #2 was diagnosed with failure to thrive at the hospital and returned to the facility after 11 days with hospice services.

When interviewed, an administrator said before his initial hospitalization, staff noticed resident #2 was coughing. He was sent to the hospital, where he was diagnosed with pneumonia. Resident #2 received IV antibiotics, after which he developed *C. diff*. Resident #2 was treated with oral antibiotics for the *C. diff*. Resident #2 returned to the facility for about a day and a half, during which the administrator cared for him. Staff were provided with appropriate PPE and re-educated regarding infection control. However, resident #2 was not eating or drinking much, so staff felt it was best to have him evaluated at the hospital. Resident #2 underwent a speech/swallow study and returned to the facility after almost two weeks, with hospice services. Hospice visited resident #2 at the facility several times a day, to provide cares, and family was actively involved in his care. As far as signing out resident #2's quetiapine and administering it to resident #1 to manage his agitation, the administrator said that was not true. Unlike bubble packaging, where each tablet of one med was packaged individually, medications were prepared by the pharmacy and placed in dose packs, so all a resident's morning medications were packed together, afternoon medications were packed together, etc. Resident

#1 had his own medications to help manage his agitation. Resident #1's family was also very involved in his care, as well as his care team.

When interviewed, a caregiver said before resident #2's initial hospitalization, nursing instructed staff to sign out resident #2's quetiapine and administer it to resident #1 to manage his agitation. The caregiver said all but one staff member followed this instruction, and the caregiver then noticed resident #2's agitation increase. The caregiver also witnessed facility leadership speaking to resident #1 in a derogatory manner on several occasions and said they were trying to transfer him out of the facility. When resident #2 returned from his initial hospitalization, the caregiver said leadership kept information about resident #2 having *C. diff* from staff and did not supply appropriate PPE for staff to protect themselves. The caregiver said eventually facility leadership managed resident #2's care themselves but did not wear appropriate PPE. Although resident #2 stayed in his room, the staff member was concerned about other residents contracting *C. diff*, as resident #2 lived in a shared room.

Resident #1's family did not feel the need to interview. There were no concerns and the family member felt resident #1 was receiving excellent care.

When interviewed, resident #2's family member said resident #2, who had recently passed away, lived at the facility for about one year. During his final hospital stay, the family member was told resident #2 was in end-stage vascular dementia. There was disagreement among the family regarding placing a G-tube and the family member felt the facility did not respect resident #2's wishes to not eat when he did not want to. The family member did not believe the care he received was in line with his diagnosis or prognosis and declined placement of the G-tube. The family member said there was pressure to unenroll resident #2 from hospice, because facility staff believed his health was improving. The family member believed there were cultural issues surrounding the feeding of resident #2, as well as issues regarding the fact that resident #2 was related to a staff member of the facility.

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

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

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

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.

"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; 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

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: No. Neither resident #1 nor resident #2 were interviewed due to cognitive status.

Family/Responsible Party interviewed: Yes, resident #2. Resident #1's family did not feel need for formal interview, no concerns.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided PPE to staff and refresher infection control training.

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
	39234	A. BUILDING: _____ B. WING _____	C 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSITY HOME CARE LLC	3853 KINGS WOOD COURT EAGAN, MN 55122

(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 June 24, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL392342750C/#HL392343426M. No correction orders are issued.	0 000	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.	