Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393707822M
Compliance #: HL393708302C

Date Concluded: April 15, 2026

Name, Address, and County of Licensee Investigated:
Adequate Home Health LLC
10255 Madison Street Northeast
Blaine, MN, 55434
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 the resident when the AP pushed the resident back into a couch, took resident's finger, bent it backwards causing a scratch to the resident's hand. In addition, the AP and other staff yelled at the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting accounts of the incident. The AP denied he pushed the resident back into his recliner or bent the resident's finger backwards causing a scratch. The AP said the scratch/cut was due to resident cutting himself on his pocketknife. A police report indicated the resident's wound on his right knuckle appeared to be a small skin tear.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager. The investigation included review of the resident records, facility incident report, law enforcement

report, facility provided video and photo images, and related facility policy and procedures. Also, the investigator observed the AP's interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included mental health diagnoses and diabetes. The resident's service plan included assistance with wound care and managing the resident's agitation, anxiety, physical aggression, verbal aggression, and self-injurious behaviors. The resident's assessment indicated the resident required as needed assistance getting in and of his chair and staff were to observe the resident's balance and positioning. The resident used a walker to walk. The resident was oriented to person, place, and time.

Progress notes indicated the resident received daily foot care. The resident developed a foot ulcer and was seen by a provider. Service delivery records and progress notes indicated the facility provided wound care/treatment to the resident's feet.

A facility incident report indicated on the day in question, the resident self-harmed using a knife, threatened other residents, was combative, had extreme agitation, was verbally abusive towards staff, threw objects (phone), hit property, and threatened to use a knife. The resident cut himself while waiting for police arrival. Staff redirected, offered a PRN (as needed) medication, called police for back up. The knives were removed for safety. An (unlicensed personal) ULP, who was a second staff member present, reported she was verbally assaulted, the resident used racial slurs, and the resident threw objects at the ULP while training on assisting with cares.

A law enforcement report indicated both the AP and resident called law enforcement. The resident became agitated and aggressive with the AP over changing bandages on his feet. The AP said the resident used racial slurs against the AP, pushed him, and put his hands in his face. The resident was agitated and yelled at the AP. The resident had several knives in his room, and the AP stated the resident stabbed his own hand, and the AP said he did not feel safe with the resident. The resident said the AP was not changing his bandages properly, pushed him, and caused a scratch to his right knuckle. The law enforcement report indicated the wound was small and appeared to be a skin tear. The resident agreed to stay in his room if bandages were changed. Law enforcement stood by while the AP continued to change the bandages. During the entire bandage change, the resident shouted at the AP. The AP advised he would like the box of knives removed from the resident's room and placed somewhere safely by the AP for safe keeping until the resident was no longer agitated. The same report indicated the resident came out of his room several times after he said he would stay in his room and tried to argue with the AP. The resident finally went to his room.

During an interview, the resident stated he had diabetic lesions on the bottom of his feet, little and big cuts. While the AP performed wound care using a cleaning solution and gauze the resident said he told the AP this was hurting him, so he asked the AP to stop. The resident said he himself threw his tablet onto his bed. The resident said he pointed his finger at the AP and

told him to stop. The resident said the AP bent his finger back. The resident said he stood up multiple times out of his recliner and the AP “shoved” him back into his recliner, multiple times. The resident said the AP used both his hands and pushed the resident in his chest as hard as the AP could. The resident said he told the AP he was going to “hit” the AP if he did it again. The resident said the AP yelled and screamed at him. The resident said ULP 1 also yelled and screamed at him on the phone, and ULP 2 had told him to “F-off” five times in a row. The resident stated there was also another ULP at the facility on the day in question, however, he could not recall if she was present in the room during the incident.

During an interview, a family member stated during the incident with the AP, the resident called the family member to listen, the family member was not physically present. The family member heard the AP and resident getting louder and louder, back and forth, about the resident’s feet/wound care and arguing. The family member heard the resident tell the AP to not get in his face. The resident then said the AP just laid his hands on me and said he pushed him. The family member did not remember what the resident was saying to the AP during the exchange. There was no recording. The family did not recall anything going on with the resident’s hand/finger. The family member spoke to law enforcement who said the resident was the aggressor.

During an interview, the AP stated he did not say anything or act in a way where the resident could have felt scared or threatened. The AP said the resident threatened others, used racial slurs, and was scary to staff at the facility. The day in question, the AP was training a ULP on how to provide the resident foot care in the event the AP was not present. The resident did not want staff to leave his room during the 30 minutes needed for the treatment solution to absorb before applying the dressings. The resident threw an object at the AP. The resident missed, and the AP dodged the thrown item. The resident gained enough strength and stamina to stand up aggressively out of the recliner and threw a punch at the AP’s face while the AP was near the resident. The AP said he used his hand and stopped/blocked the resident’s hand. The resident was unable to hold onto his balance and landed back into the recliner. The AP stated he was surprised the resident had enough stamina to stand up however the resident aggressively stood up and swung at the AP’s face. The AP said he did not see or expect the punch to come and it happened very quickly. The AP denied pushing or laying hands on the resident. The AP also denied bending the resident’s finger backwards causing a cut. The AP said the cut on the resident’s finger was due to the resident attempting to open the pocketknife and cut himself. The AP said he had a photo image of the pocketknife. The AP said you cannot bend a finger backwards to cause a scratch/cut to the skin. The resident threatened to stab staff. The facility staff were also unaware of the resident knives in his room. The AP had staff call leadership (ULP 1) to be on the phone to assist in de-escalation. After the resident swung a punch, the AP said he had a recording with the resident stating he was going to punch him in the face. This was captured after the resident swung a punch. The AP called law enforcement for support and finished dressing the resident’s feet in the presence of law enforcement. The knives were removed from the resident’s room for safety. After the incident, the resident’s wound care was performed out of his room. The AP said if there was yelling it would be in the context of a

healthcare provider yelling out for help, being assaulted by someone was violent. The AP said the ULP he was training on wound care was present during the exchange.

Facility provided photo images viewed included a closed pocketknife, numerous sharp items, and another knife. A video showed the resident pointing at the AP and shouted at the AP he was going to “hit you right in-between you God damn eyes.” The AP told the resident if the resident continued to act this way he was going to have to call the police.

During the course of the investigation, attempts to reach the ULP, who was identified as the second staff member present on the day in question were unsuccessful.

During investigative interviews, multiple ULPs stated they did not hear anyone say anything or act in a way where the resident could have felt fearful or threatened. ULP 1 said she was on the phone and overheard the resident speaking to staff the day the police were called. ULP 1 stated she did not hear anyone yelling at the resident. ULP 1 also stated she did not yell or raise her voice while speaking with the resident. ULP 2 stated the resident never complained or voiced that anyone at the facility yelled at him and the resident did not say why he was moving out. ULP 2 also stated she did tell the resident to “fuck off.”

In conclusion, the Minnesota Department of Health determined abuse 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 provided wound care to the resident’s feet. The facility coordinated transfer to the new facility the resident discharged to.

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
	39370	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

(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 April 1, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL393708302C/#HL393707822M. No correction orders are issued.	0 000		