

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL399596703M
Compliance #: HL399599992C

Date Concluded: March 11, 2025

Name, Address, and County of Licensee

Investigated:

Bimsol Home Care LLC
5542 Unity Ave. North
Crystal, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 abused the resident when staff yelled at the resident and kicked her in the head. Additionally, facility staff neglected the resident when the resident was found on the ground smelling of urine.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse and neglect were not substantiated. The facility assessed the resident for areas of vulnerability and implemented interventions to address the resident's concerns. Although the resident reported emotional abuse, physical abuse, and neglect from staff, there was no corroborating evidence to support abuse or neglect occurred. The facility was aware of the resident's concerns and discussed the concerns with the resident's respective care teams.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the case

worker and the physician. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral palsy, urinary incontinence and anxiety. The resident's service plan included assistance with all activities of daily living including transfers and incontinence cares. The resident's assessment indicated the resident was oriented to person, place and time.

A police report indicated a well check was requested on the resident for allegations of abuse and neglect. Upon officer's arrival at the facility, the resident was on the floor. The resident told officers she lived on the floor waiting to die and reported facility staff kicked her in the head.

The resident's medical record indicated the resident complained of hip pain during the well check and was sent to the hospital for evaluation.

Hospital records indicated after discussion with the social worker, thorough chart review and conversation with the guardian indicated the resident had been making claims about staff for several years with no evidence found to substantiate the claims. The resident was sent back to the facility with no findings of injury.

Review of medical provider notes indicated during onsite visits the resident was verbally offensive to staff and refused assistance. The medical provider notes indicated the resident exhibited attention seeking and manipulative behaviors and needed additional mental health support.

During an interview, the resident stated she preferred to be on the floor because of her cerebral palsy and that she couldn't move around on the bed like she could on the floor. The resident stated facility staff would made fun of her voice and kicked her in the head. The resident stated she refused cares because the staff don't wash their hands.

During investigative interviews, facility staff stated the resident preferred to be on the floor instead of her bed. Facility staff denied hitting, kicking, yelling or neglecting the resident. Facility staff stated the resident refused cares and the refusals were documented.

During an interview, the facility nurse stated the resident had a history of reporting neglect and abuse prior to moving into the facility. The behaviors were care planned and the facility communicated the allegations with the resident's care team.

During an interview, the guardian indicated there was no concerns with the facility, they have gone above and beyond for the resident.

In conclusion, the Minnesota Department of Health determined abuse and neglect were 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:

(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.

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 investigated reported allegations and collaborates with the resident's care team.

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: 39959	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2025
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NAME OF PROVIDER OR SUPPLIER BIMSOL HOME CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5542 UNITY AVENUE NORTH CRYSTAL, MN 55429
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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>Initial Comments</p> <p>On February 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL399599992C/#HL399596703M. No correction orders are issued.</p>	0 000		

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