Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL399958823M
Compliance #: HL399956603C

Date Concluded: June 12, 2025

Name, Address, and County of Licensee Investigated:
Minnesota Home and Health Care
6008 Rhode Island Ave N.
New Home, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, 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 facility and alleged perpetrator (AP), facility staff, neglected a resident when they did not supervise the resident while he was outside smoking in inclement weather. As a result, the resident fell and suffered frostbite to both hands, a right leg fracture, and rhabdomyolysis (break down of muscle, releasing toxins into the bloodstream).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. While the resident did go outside to smoke, the resident's plan of care was being followed at the time of the incident. Despite being educated on the risk of being outside in below zero temperature, the resident went outside independently multiple times day and night in cold weather without issues. The resident stated the AP was sleeping when he went outside and he laid outside on the ground for around four hours however, the AP stated he was awake, and the resident was outside for around 10 to 15 minutes.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted two case workers. The investigation included review of facility policy and procedures, employee and resident records, hospital records, and weather reports for the incident date.

The resident resided in an assisted living facility for approximately two months. The resident's diagnoses included Parkinson's disease, major depression, bipolar disorder, type 2 diabetes with neurological (condition that affects the nervous system) complications, anxiety, borderline personality traits. The resident had a history of verbal and physical aggression toward staff and other residents. At the time of the incident, the resident's service plan indicated the resident used a walker as needed with ambulation, the resident fell easily because of his Parkinson's disease, and needed standby assist with grooming, dressing, and medication management.

Review of the resident housing and services contract indicated under security/valuables/keys, the facility provided a security system including cameras in common areas, alarmed doors, and secured keypad locks. The residents would not be assigned a key for the front entrance of the facility. The facility was staffed 24 hours a day. In addition, the contract stated the resident were free to leave the facility whenever they chose.

The progress noted indicated three days prior to the incident, at 9:07 p.m. when staff arrived at the facility for their shift, the resident was outside smoking in the cold weather. When staff advised the resident it was too cold to be outside, the resident became angry with the staff, yelling that it was none of their business, and insisted he was fine with the cold weather. Staff continued to encourage the resident to go inside the facility, but the resident became angrier. The resident went to his room and hit the wall, isolated himself, and required an as needed medication for anxiety. The night prior to the incident, staff documented at 3:00 a.m., the resident frequently went outside to smoke, about four times before 5:00 a.m. Each time, staff advised the resident to be careful because it was very cold.

The incident report indicated the following early morning around 4:00 a.m., the resident went out to smoke and fell in front of the facility. Around 4:10 a.m. the AP heard the resident calling for help and immediately went outside. The resident was wearing shoes and a jacket. The resident stated he slipped and fell on the ground and was not able to get up on his own. The AP contacted 911 for assistance and for the resident to be evaluated at a hospital.

The initial hospital record indicated the resident went outside to smoke a cigarette at 0400 a.m. At 04:35 a.m. emergency services were contacted for the resident who had slipped and fallen on the driveway of the facility. The windchill temperature at that time of the incident was minus 11 degrees Fahrenheit. The resident was found lying on his back with no obvious injures. The report indicated the resident's hands were very cold with a white tint from knuckles down to fingertips. The resident stated he went out for a smoke around 1:00 a.m. and slipped on ice, causing him to fall on his knees. The resident was unable to get up and was outside for four

hours before he was found. The discharge diagnoses included frostbite of both hands, closed non-displaced fracture right fibula (calf bone), and a contusion (bruise) of the left knee.

A progress noted indicated the resident was evaluated at a hospital for altered mental status, infection, difficulty breathing, a fall with injury and fever. About four hours later the resident was discharged from the hospital with instructions to follow-up about three days later at a burn center for frostbite. Instead, the family chose to take the resident to another hospital for an evaluation.

The resident's second hospital record admission indicated the resident's diagnoses included frostbite of left and right hand, right upper fibula fracture (small bone located on the outside of the leg), low blood pressure due to significant fluid loss, influenza, pneumonia, elevated troponin (indication of heart stress or damage), confusion, encephalopathy (brain dysfunction) and rhabdomyolysis (break down of muscle, releasing toxins into the bloodstream). The record indicated the family refused the hospital discharge plan. The resident was admitted to the hospital following hallucinations, acute delirium (change in mental status), and hypotension (low blood pressure). The resident discharged from the hospital to a higher level of care six days later with a good potential to return to the resident's prior level of functioning and mobility.

During an interview, the licensed nurse stated prior to the fall, the resident was independent with smoking. The licensed nurse stated a smoking assessment was completed for the resident on admission.

During an interview, a manager stated the resident's initial smoking assessment was done by the registered nurse. The manager stated during the time the resident went outside, the facility camara was not positioned correctly and did not capture movement when all the lights were off.

During an interview, the resident stated he was a frequent faller because he shook really bad. The resident stated he went out to smoke at 1:00 a.m. and there was a worker sleeping in a chair next to the door. The resident stated the worker did not wake up when he went out and he did not wake him because he did not think that he was going to fall. The resident stated he fell and was laying outside for four hours. The resident stated he tripped and fell and fractured his leg and started yelling for help. The resident stated he did not remember who got him up off the ground. The resident stated he sustained frostbite to both hands requiring him to be treated at the burn center.

During an interview, a family member stated the resident told her the AP was sleeping in the living room when the resident went outside to smoke early in the morning. The resident told the family member he fell and was calling for help. The resident told the family member he was outside for about three to four hours.

During an interview, the AP stated the resident was independent and only required help when he called for staff. The AP stated the resident was not on standby assist or safety checks before the incident. The AP stated he was in the living room and not sleeping when the resident went out to smoke. The AP stated the resident went out around 4:00 a.m. and he heard him calling for help at 4:10 a.m. to 4:15 a.m. and the resident sustained frostbite because it took the ambulance time to respond.

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.

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 stated they would have functional surveillance camara and door alarm and would work with resident and family to establish physical therapy and appropriate equipment for the resident. The facility provided safety checks for the resident, completed a smoking assessment, and care planned the resident to be supervised by staff when outside smoking.

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
	39995	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA HOME AND HEALTH CARE LLC	6008 RHODE ISLAND AVENUE NORTH 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****** HOME CARE PROVIDER/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: #HL399956603C/#HL399956823M #HL399956603C/#HL399958823M On February 25, 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 XX clients/ residents receiving services under the provider's Basic/Comprehensive Home Care Assisted Living/Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HLHL399956603C/#HL399956823M, tag identification 2350.	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.	
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with	02350		

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02350	Continued From page 1 courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure a resident was treated with courtesy and respect for one of three (R1) residents reviewed. 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1 was admitted to the facility on June 21, 2024, with diagnoses that included severe depression, anxiety, seizure disorder, bipolar disorder, and chronic back pain. R1's care plan indicated R1 received services for medication management, behavior management, transportation, and meal preparation. R1's vulnerability assessment dated December 1, 2024, indicated R1 was vulnerable in the areas of anxiety and depression, destruction of property and potential risk to others because of her aggressive behaviors of hitting and verbal abuse. During an interview on February 25, 2025, at 11:01 a.m., R1 stated she was locked in the backseat of the AP's car for about five minutes. R1 stated she was unable to let herself out because the child lock was on. R1 stated the AP	02350		

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02350	Continued From page 2 was laughing during the incident. R1 stated after the incident AP would say things under her breath about her and treated the other residents nicer which made her feel like a child. During an interview on February 25, 2025, at 1:22 p.m., management stated R1 reported to him the AP refused to turn down the volume on the radio while driving. R1 stated to him that she became upset and grabbed the AP from behind. R1 went on to say that she did not want the AP to drive her anymore because of the incident. During an interview on April 22, 2025, at 10:25 a.m., unlicensed personnel (ULP)-A stated that when transporting R1 ULP_-A was listening to the radio when R1 became upset, told her it was too loud and to turn it off. ULP-A told R1 that it was her car and not a company car and did not turn down the radio. R1 was sitting in the back seat and proceeded to grab ULP-A by the back of her hair. ULP-A pulled the care over to the side of the rode and told R1 she was going to call the police. When ULP-A and R1 arrived at the facility R1 was still upset. ULP-A contacted her supervisor about the situation and told R1 she would not let her out of the car until she calmed down. ULP-A stated R1 began screaming and kicking the window, so she unlocked the car door and ran in the house. ULP-A stated R1 came in the house and started throwing things at her. ULP-A stated that after a while resident #1 calmed down. The licensee's policy titled Home Care Bill of Rights undated, indicated residents have the right to be treated with courtesy and respect. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02350		