Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339554023M
Compliance #: HL339556677C

Date Concluded: October 16, 2023

Name, Address, and County of Licensee Investigated:
Empathy Home Care, INC
6501 Brooklyn Drive
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger, RN and Lisa Coil, RN Special Investigators

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, alleged perpetrator (AP) 1 and AP 2 abused the resident when AP 1 and AP 2 locked the resident in the basement.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While it was true the resident was locked in the basement, AP 1 and AP 2 denied intentionally locking resident in basement and it was possible the door was locked inadvertently.

The investigator conducted interviews with facility nursing staff, unlicensed staff, and residents. The investigation included review of the resident's medical records including assessments, progress notes, and the service plan. The investigator also reviewed the facility's internal investigation, policies, employee records, and contacted law enforcement.

The resident lived in an assisted living facility. The resident's diagnoses included schizophrenia, anxiety, and agitation. The residents nursing assessment indicated the resident needed encouragement and cueing to socialize due to a tendency to isolate himself.

A progress note indicated the resident called 911 stating the assisted living staff had locked him in the basement. The law enforcement report indicated the resident called 911 reporting the staff had locked him in the basement, he was beating on the door and the staff members were not letting him out.

The law enforcement report indicated when police arrived the basement door was open. The police report did identify the door handle was backward, with the key lock facing into the basement and the locking/unlocking switch facing towards the kitchen/living area. The report indicated AP 2 said the door could have accidentally been locked. The same document indicated the site manager was aware of the door handle locking mechanism.

During an interview, AP 1 stated the door was not locked intentionally and it could have been accidentally locked by a staff member or other residents. He stated the door was unlocked as soon as the staff members became aware of it.

The attempts to contact AP 2 were not successful.

During an interview, the resident stated he reported the door was locked and he did not have a key to open the door. The resident denied the door was locked on any other occasion.

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:
(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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: AP 1 was interviewed. Attempts to interview AP 2 were unsuccessful.

Action taken by facility:
Changed door handle after report of incident.

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
	33955	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPATHY HOME CARE INC	6501 BROOKLYN DRIVE 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 On August 29, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL339556677C/#HL339554023M. No correction orders are issued.	0 000		