Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347311200M
Compliance #: HL347318662C

Date Concluded: January 30, 2024

Name, Address, and County of Licensee Investigated:
Empathy Home Care Inc
7325 Kentucky Avenue North
Brooklyn Park, Minnesota 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 neglected the resident when the resident's boyfriend physically abused her. The resident sustained excessive bleeding from the nose and went to the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided information on domestic violence, scheduled appointments with a therapist, and tried to discourage the resident from seeing her boyfriend. Ultimately, the resident was her own responsible party and decided to continue leaving the facility to see him.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included high blood pressure and mental health disorders. The resident's service plan included assistance with medication administration, behavior management, and safety checks. The resident's assessment indicated the resident had a high risk for falls and required the use of a walker for longer distances.

While out of the facility visiting her boyfriend, the resident sustained an injury to her face. The owner of the facility was made aware of the incident.

An incident report indicated the resident had been found on the floor, bleeding excessively through the nose. A witness called emergency medical services (EMS) who transported the resident to the emergency department (ED).

The ambulance run indicated EMS arrived at the resident's boyfriend's residence for assault. Upon arrival, EMS observed the resident had a swollen nose and possible black eye. Witnesses informed EMS the resident had been assaulted by her boyfriend. The resident told EMS she fell but did not remember how. EMS assessed the resident and transferred her to the ED.

The resident's hospital record indicated the resident reported she and her boyfriend were arguing, then she woke up bleeding, noting she might have passed out. The resident sustained a broken nose from the incident. The resident admitted to the hospital for approximately one day until she requested multiple times to leave.

During an interview, the owner denied being aware of any previous physical altercations between the resident and her boyfriend but believed the resident's injury had been due to the boyfriend physically abusing her. The owner discouraged the resident from continuing to leave the facility to see him, but the resident continued to go see him. The owner set up appointments for the resident to speak with a therapist about domestic violence, but the resident declined to go to the first two appointments. The owner also provided information on domestic violence, notified her case manager, and instructed facility staff not to provide rides over to her boyfriend's house.

During an interview, a witness stated she saw the resident and her boyfriend, who were talking and having fun. They went downstairs to his room, and after about five minutes she heard the resident scream. The witness went downstairs and found the resident bleeding from the nose. The resident did not tell the witness what happened. The witness called 911 and notified the facility's program manager.

During an interview, the resident stated she had been visiting her boyfriend when she slipped and fell, hitting her face on a table or dresser. The resident denied her boyfriend physically abused her. The resident stated she had not been using her walker at the time she fell.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: No. The resident was her own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided domestic violence information, scheduled three therapy appointments, and discouraged the resident from visiting her boyfriend.

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
	34731	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPATHY HOME CARE INC	7325 KENTUCKY AVENUE NORTH BROOKLYN PARK, MN 55428

(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 January 9, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL347318662C/#HL347311200M. No correction orders are issued.	0 000		