Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347311440M
Compliance #: HL347318913C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Empathy Home Care
7333 Kentucky Ave. North
Brooklyn Park, MN 55428
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 neglected the resident when the resident was physically combative and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the incident occurred, facility staff attempted de-escalation interventions at the time of the incident. When interventions were unsuccessful staff contacted the police. The resident was hospitalized and discharged to a new facility.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also contacted the resident's case worker. The investigation included review of the resident's record, hospital records, facility internal investigation documentation, facility incident reports, staff schedules, law enforcement reports, and related

facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included mild intellectual disabilities and depression. The resident's service plan included assistance with medication management and behavioral support. The resident's assessment indicated the resident had a history of verbal and physical aggression.

The resident's medical record indicated the resident admitted to the facility four days prior to the incident and was noted to have increased anxiety, pacing, was nervous, and had refused her medications. Facility staff attempted re-direction, talked with the resident about her interests, watched TV with her, called her parents for her to talk to them, offered as-needed medication and when staff noted anxiety or agitation, the nurse was updated.

The day of the incident, the resident started hitting at staff stating that she wanted to go home. The facility nurse was called and attempted to talk with the resident, but the resident became increasingly agitated and threw the living room table, couch, and chair, at the facility nurse. Facility staff then contacted 911.

The police report indicated the resident's behavioral issues were potentially associated with adjusting to the new living situation and police decided to leave the resident at the facility. The police report indicated to call 911 if the aggressive behaviors escalated.

Facility staff offered to take the resident on an outing later that day. While in the car, the resident became upset and started hitting at staff and attempted to turn the car off while staff were driving. When the resident returned from the outing, the resident went into the kitchen and started hitting staff members and another resident. Facility staff called 911 again and the resident was taken to the emergency room for evaluation.

Hospital records indicated the resident's family reported that the resident lived with her parents until recently when the resident's mother became ill, and the resident's behaviors increased. Hospital records indicated the resident was hospitalized for two months after the incident and was later discharged to a new facility.

During an interview, the facility nurse stated the resident had behaviors prior to admission and the facility had interventions in place; however, the resident started refusing medications and became aggressive with staff and other residents. The resident's family member later reported to the facility nurse that they felt the resident's medications were not correct and the resident needed hospitalization to get the medications figured out. The resident did not return to the facility after her hospitalization.

Facility staff employed at the time of the incident did not respond to requests for interview.

The resident’s case manager did not respond to requests for interview.

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: No. Resident unavailable for interview
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility developed and implemented interventions to deescalate the resident’s behaviors. When interventions were not effective, staff contacted 911.

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 05/20/2024

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 May 20, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL347318913C/#HL347311440M. No correction orders are issued.	0 000		