



*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL348822780M

**Date Concluded:** August 25, 2024

**Compliance #:** HL348822381C

**Name, Address, and County of Licensee**

**Investigated:**

Hope Rest Homes

7553 University Ave NE

Fridley MN 55432

Anoka County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Maggie Regnier

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 alleged perpetrator (AP) abused a resident when he yelled "I will kill you."

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was inconclusive. Neither the AP nor the resident was available for interview nor were any witnesses identified.

The AP worked at the facility as an unlicensed caregiver and was no longer employed at the facility before the AP could be asked about this incident.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator attempted multiple times to contact the AP and the vulnerable adult involved. The investigation included review of medical records, facility records, education and training records, employee records, policies, and procedures. Also, the investigator observed staff interactions with residents, staff and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included multiple mental health disorders. The resident's service plan included assistance with verbal cueing for bathing, dressing and grooming. The resident also required medication and behavior management. The resident's assessment indicated he had a tendency towards paranoia and delusional thoughts.

A facility incident report indicated it was claimed the AP threatened the resident by saying "I will kill you" to a staff member. The AP's employment was terminated although the resident's claim was not discussed with the AP.

During an interview, the staff member stated he did not ask the AP if he said "I will kill you" to the resident or inquire about the incident prior to the end of the AP's employment.

During an interview, the manager stated the facility did not discuss the resident's concern with the AP prior to the end of this employment. The manager stated the resident had since moved away and was no longer at the facility.

A review of the pertinent documentation did not identify any witnesses to the alleged event.

In conclusion, the Minnesota Department of Health determined abuse 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.

**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:** Attempts unsuccessful

**Family/Responsible Party interviewed:** none listed

**Alleged Perpetrator interviewed:** Attempts unsuccessful

**Action taken by facility:**

The AP was no longer employed at the facility.

**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:  <b>34882</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 07/24/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOPE REST HOMES INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>7553 UNIVERSITY AVENUE NE FRIDLEY, MN 55432</b>		
(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 July 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL348822381C/#HL348822780M. No correction orders are issued.	0 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE