

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL353862463M

**Date Concluded:** January 26, 2023

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

**Investigated:**

Delight Home Healthcare  
8117 Hampshire Court North  
Brooklyn Park, MN 55445  
Hennepin County

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

**Evaluator's Name:** Lori Pokela R.N.  
Special Investigator

**Finding:** Inconclusive

**Nature of Visit:**

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 perpetrators (AP)-1, AP2, AP3, and AP4) verbally abused the resident by using abusive language and telling the resident phrases that triggered self-injurious behavior. In addition, the alleged perpetrators (AP)-1, AP2, AP3, and AP4) neglected the resident by administering medication to the resident at incorrect times.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined verbal abuse was inconclusive. Although the resident engaged in self-injurious behavior, the cause of the behavior could not be established. When staff became aware of the injury, treatment was provided, and the resident was sent to the hospital for a mental health evaluation. It is unable to be determined if the alleged conduct of the APs occurred or if it triggered the resident's self-injurious behavior. The resident did not identify AP2 or AP3 as alleged perpetrators of verbal abuse or neglect.

The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to support the resident's medications were administered at the wrong times.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and interviewed hospital personnel. The investigation included review of the resident's medical records, review of relevant facility records, and an onsite visit was conducted to complete observations of facility processes and provision of care.

The resident resided in an assisted living facility. The resident's diagnoses included Borderline Personality Disorder, Bipolar Disorder and Generalized Anxiety Disorder. The resident's service plan included assistance with some activities of daily living (ADL's), medication administration, mental health monitoring, and safety checks. The resident's assessment indicated the resident had a history of multiple emergency department visits, self-injurious behavior, suicidal ideation, physical aggression, verbal aggression, paranoia, delusions, and hallucinations. Staff was directed to monitor daily for manipulative-type behaviors.

The resident's medication administration record (MAR) was reviewed and indicated all scheduled medications were administered at the correct times. The MAR also included documentation of the resident's refusals to take medication as prescribed.

A facility incident report indicated the resident reported to staff that she had cut herself, and was going to call law enforcement to tell them [law enforcement] that "they", [the staff], had been the ones that cut her. The incident report also indicated first aid was provided to the resident, 911 was contacted, and staff monitored the resident for safety until law enforcement arrived.

When law enforcement arrived at the facility, the resident was standing in the driveway and reported that staff verbally abused her and as a result, she had cut her own hands and leg. Law enforcement asked the resident if she wanted to go to the hospital, and the resident was transported, via ambulance, to the hospital for a mental health evaluation.

The resident reported to emergency room personnel that facility staff verbally abused her which caused her to have suicidal ideations and cut her own left arm and left leg. The resident was assessed, and no treatment was provided related to the cuts on her left arm and leg. The resident was admitted for observation and a mental health evaluation was completed. The resident discharged back to the facility the next day.

During an interview, the resident stated two staff (AP1 and AP4) made verbally abusive comments towards her since her admission to the facility which triggered her to cut her own left arm and left leg. The resident stated both AP1 and AP4 told the resident to "shut the fuck up" and "I hope you cut deep enough to die". The resident stated AP4 told her and another

resident (R2), that they were dirty and treated them both like children. Later in the interview, the resident stated it was AP1 who told her to “shut the fuck up” and “I hope you cut deep enough to die”. The resident then stated AP1 was the staff who caused her to cut herself. In reference to the alleged medication errors, the resident indicated she did not agree with the process that PRN medications were being administered. The resident stated PRN (as needed) medications were brought to her by staff and then staff would ask if she [the resident] needed them. The resident felt she should be requesting PRN medication before staff bring her the medication. The resident could not provide details of any occurrence of medications being administered at the incorrect times.

Resident 2 (R2) was interviewed and stated she had good rapport with the resident. R2 stated she heard AP1 tell the resident that if she wanted to kill herself, she should just do it. R2 also stated she, and the resident, were told by AP4 that they live like “pigs” and should be disciplined like children.

Review of the police report from the day the incident occurred, indicated the resident alleged staff had verbally abused her but provided no specific statements or details of the alleged abuse. No specific staff or APs were identified in the report.

During an interview, the administrative nursing staff stated they were aware of allegations of verbal abuse by staff but did not know of specific statements or identities of the staff who had allegedly verbally abused the resident. In addition, administrative staff was not aware of any allegations brought to them from R2 regarding staff abusing R2 or the resident. Administrative staff indicated the resident frequently fabricated stories which made it a challenge to know if the resident was really in a mental health crisis or not. For this reason, the facility always agreed to send the resident to the emergency room whenever she requested. Regarding medications, the administrative nursing staff stated the facility ensured daily that the resident had swallowed her medications, as she had a history of hiding the medications in her room. Administrative nursing staff stated the resident frequently refused to take her medications. Administrative nursing staff was not aware of any recent medication errors that had occurred with the resident’s medication.

During an interview, the resident’s family member stated the resident had a history of cutting, suicidal ideation, manipulative behavior, filing multiple complaints on staff even at previous facilities, making multiple 911 calls, and multiple emergency room visits. The family stated they were notified about the incident and hospitalization but could not recall who notified them. The family stated the resident historically heard voices that no one else could hear and did not believe that staff were verbally abusive. The family member also stated that if the resident overheard a verbally abusive statement from another resident, she very well could have attributed that the statement was made towards her by a staff member or someone else. The family member did not think that staff verbally abused the resident based on his observations when visiting the facility and the resident’s history of behaviors.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive and neglect was not substantiated.

**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.

**"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.

**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: AP2, AP3 and AP4 were interviewed.  
AP1 declined to be interviewed.

**Action taken by facility:**

The facility completed an incident report and contacted emergency response services.

**Action taken by the Minnesota Department of Health:**

No further action to be 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>35386</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DELIGHT HOME HEALTHCARE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8117 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445</b>
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(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	<p><b>Initial Comments</b></p> <p>On December 6, 2022, the Minnesota Department of Health initiated an investigation of complaints: HL353862463M/HL353864334C and HL353863709M/HL353866145C</p> <p>No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_