Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL353867065M
Compliance #: HL353863449C

Date Concluded: March 29, 2024

Name, Address, and County of Licensee Investigated:
Delight Home Healthcare LLC
8117 Hampshire Court N.
Brooklyn Park, MN 55445
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 they failed to ensure adequate supervision was implemented to ensure the resident's safety while she resided at the facility. The resident was sexually assaulted by two unknown males while unsupervised in the community.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident assessments indicated the facility would ensure the resident was always safe by providing 1:1 supervision while the resident was out in the community. The resident left the facility for days at a time without staff supervision or knowledge of her whereabouts.

The investigation included interviews with a social worker, the resident's guardian, facility leadership, unlicensed staff, and a current resident of the facility. The resident was interviewed. The investigation included review of the resident's emergency room (ER) and hospital records,

law enforcement reports, interdisciplinary team member's notes, care plan, individual abuse prevention plan (IAPP), assessments, progress notes, and incident reports. The facility's policies and procedures were reviewed.

The resident resided in the assisted living facility for seven months. The resident's diagnoses included borderline personality disorder, polysubstance abuse, and suicidal ideation. The resident received two daily safety checks every 12 hours and walked independently.

The resident's record indicated the resident had poor safety awareness. The resident was at risk for being abused, self-abuse, and abusing others due to her history of elopement, wandering, polysubstance abuse, inappropriate behaviors which included sex trafficking, and suicidal ideation. The facility was to ensure the resident was always safe by providing 1:1 supervision while the resident was out in the community.

The resident's record indicated one summer night at 6:30 p.m., the resident applied makeup and left the facility telling staff her intentions were to have a "fun outing." The resident left the facility without staff supervision.

The resident's emergency room record indicated eight hours later, between 2:00 a.m. and 3:00 a.m., the resident reported she was sexually assaulted twice by unknown males. The resident told hospital staff she had been at a bar with friends, drinking and smoking pot (marijuana) prior to the assaults so she did not recall the names of the men. The resident stated she walked around for a while before she decided to be evaluated at the hospital. The resident reported vaginal, knee, hip, rib, and back pain. The resident also had abrasions on both knees and bruising on her upper left arm.

One month later, the resident left the facility without informing the unlicensed personnel. The unlicensed personnel documented "no health concerns." The resident returned to the facility 55 hours after she left the facility. The resident stated she used methamphetamine (meth) and slept with 10 different men while unsupervised in the community.

Four months later the resident left the facility unsupervised and would not tell unlicensed staff where she was going. Eight days later, the resident went to a hospital not knowing her whereabouts. The resident told facility staff she wanted to check into a treatment center stating, "I have been out on the street doing drugs for days and sleeping around with all types of men." Six days later, the resident was discharged from the facility into a treatment center.

During an interview, unlicensed personnel stated the resident eloped "a lot," and needed staff with her whenever she left the facility. The unlicensed personnel stated they went out with the resident one time, stating the resident enjoyed the company. The unlicensed personnel stated facility staff would sometimes call law enforcement when the resident left the facility without facility staff but stated, "you can't force her to stay."

During an interview, facility leadership stated they staffed one unlicensed staff person per 12-hour shift at all five facilities they owned in the area. Facility leadership stated between the hours of 7:00 a.m. and 7:00 p.m., they also had three staff who “floated” between the facilities. Facility leadership stated residents who required 1:1 staff supervision in the community meant staff were supposed to always be with the resident. Facility leadership stated, “since they (the residents) have rights you can’t hold them back.”

During an interview, the social worker stated the resident did not understand risks and was vulnerable to abuse.

During an interview, the resident stated she and other residents were able to come and go from the facility as they pleased. The resident stated, “they (facility) did not do shit for me.” The resident stated she and other residents were allowed to come and go as they pleased, and stated during the times she was unsupervised in the community she took drugs and engaged in sex with multiple unknown men.

During an interview, the resident’s guardian stated facility leadership told the guardian the resident would not be allowed to have alone time in the community without facility staff, stating that was the main reason they moved the resident into the facility. The resident’s guardian stated after the resident’s sexual assaults, the guardian asked facility leadership why the resident was allowed to leave the facility without supervision. Facility leadership stated there was nothing the facility could do when the resident left the facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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. Both the social worker and guardian were interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The resident was discharged to a treatment center.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35386	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HOME HEALTHCARE LLC	8117 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445

(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 ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL353863449C/#HL353867065M On January 18, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following corrections order are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL353863449C/#HL353867065M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1	0 000	No plan of correction is required for tag 2360.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) reviewed. The licensee failed to ensure facility staff supervised R1 while she was away from the facility, and failed to ensure adequate supervision was implemented after R1 was sexually assaulted by two unknown males while unsupervised. In addition, the licensee failed to immediately update R1's case manager (CM)-D and legal guardian (LG)-C after R1's elopements. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	02310		

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02310	Continued From page 2 The facility's uniform disclosure of assisted living services and amenities (UDALSA) indicated the facility staffed one unlicensed personnel (ULP) per 12-hour shift. R1's medical record indicated R1 was admitted to the licensee's facility on April 25, 2023. R1's diagnoses included bipolar disorder, cognitive disorder, and post-traumatic stress disorder (PTSD). R1's care plan dated May 10, 2023, indicated R1 had a history of wandering, drug abuse, and impaired judgement. R1's individual abuse prevention plan (IAPP), dated May 1, 2023, indicated R1 would be provided additional staff supervision whenever she left the facility due to her history of sexual inappropriateness around children. R1's service delivery records indicated R1 received two daily safety checks during the morning and overnight shifts. R1's progress note dated June 16, 2023, at 4:32 a.m., stated on June 15, 2023, at 11:27 p.m., R1 left the facility and returned on June 16, 2023, at 3:41 a.m. R1's record lacked documentation staff supervised R1 while she was out in the community. R1's progress note dated June 16, 2023, at 6:33 p.m., indicated at 6:30 p.m., R1 applied makeup and left the facility telling staff her intention was to have a "fun outing." R1's record lacked documentation staff supervised R1 when she left the facility and lacked documentation R1's LG-C and CM-D were notified.	02310		

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02310	Continued From page 3 R1's hospital record dated June 17, 2023, at 3:14 p.m., indicated on June 16, 2023, around 2:00 a.m., R1 reported she was sexually assaulted by two unknown men. R1 indicated prior to the assault she drank and smoked marijuana with friends and was unable to recall the names of the men who sexually assaulted her. R1 stated she walked around for a while before she decided to be evaluated at a hospital. R1 reported knee, back, arm, lip, and vaginal pain. R1 was discharged back to the facility a few hours later. In an email dated June 22, 2023, at 4:04 p.m., from CM-D to RN-B, CM-D detailed concerns she and LG-C had regarding RN-B's lack of notifying them about R1's sexual assault and multiple elopements. CM-D indicated R1 went to the emergency department three times within the past two months, yet RN-B failed to update them and provide CM-D and LG-C with incident reports, or documentation regarding R1's elopements and hospitalizations. In an email dated June 22, 2023, at 4:51 p.m., from RN-B to LG-C and CM-D, RN-B indicated R1 did not elope on June 16, 2023, but told staff she was "going for a walk." RN-B indicated she tried to prevent R1 from leaving but was unable to stop her. In an email dated June 26, 2023, at 8:29 p.m., from RN-B to LG-C and CM-D, RN-B indicated she sent messages to all staff to complete elopement incident reports, call 911, or call RN-B whenever R1 left the facility. R1's progress note dated July 30, 2023, at 6:40 a.m., indicated on July 29, 2023, at 12:00 a.m., R1 left the facility without informing staff. Staff	02310		

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02310	Continued From page 4 documented "no health concerns." R1's record indicated staff did not report R1 missing until July 29, 2023, at 7:21 a.m., seven hours after she left the facility unsupervised. In an email dated July 31, 2023, at 8:44 a.m., from LG-C to RN-B, LG-C wrote, "Am I understanding this correctly? R1 left on Saturday, (7/29/23), and you haven't seen her since?" LG-C indicated she and CM-D were to be notified immediately, or within 24 hours, and asked RN-B, "Why are we just hearing about this two days later?" R1's progress note dated July 31, 2023, at 9:20 a.m., indicated at 9:49 a.m., R1 returned to the facility after being missing for over 55 hours. R1 stopped by to pick up some items then left the facility to leave in a vehicle parked outside the facility. Facility staff called law enforcement to the facility. R1 told law enforcement she had been using meth (methamphetamine) and slept with 10 different men while missing. R1 requested she be evaluated at the hospital for overusing meth. R1's progress note dated November 14, 2023, at 11:00 p.m., indicated on November 14, 2023, at 10:00 p.m., R1 left the facility unsupervised in an unknown vehicle. R1's progress note dated November 16, 2023, at 6:20 p.m., indicated R1 left the facility with a friend after she made a few phone calls but returned 30 minutes later. ULP-A wrote, "No health concerns." R1's incident report dated November 19, 2023, at 5:51 p.m., indicated unlicensed personnel (ULP)-A saw R1 leave the facility. R1 would not	02310		

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02310	Continued From page 5 tell ULP-A where she was going when she left. R1's progress note dated November 27, 2023, at 10:56 p.m., indicated an ER called the facility stating R1 was in the ER and would be discharged back to the facility. R1's progress note dated November 28, 2023, at 9:03 a.m., indicated R1 told staff she was going to check herself into a treatment center stating, "I have been out on the street doing drugs for days and also sleeping around with all type of men." In an email dated December 1, 2023, at 12:01 p.m., from CM-D to LG-C, CM-D indicated R1 stated she needed to move out of the facility because it was so easy to obtain street drugs. R1's progress note dated December 7, 2023, at 11:07 a.m., indicated R1 was discharged from the facility to a treatment center. On January 18, 2024, at 1:24 p.m., ULP-A stated R1 was supposed to have staff supervision while out in the community. On January 19, 2024, at 9:00 a.m., LG-C stated the facility promised her and CM-D, R1 would have no alone time in the community, stating that was the main reason they moved R1 into the facility. LG-C stated she talked to RN-B after R1's sexual assault asking RN-B why R1 was able to leave the facility without staff supervision. LG-C stated, "RN-B said there was nothing they (facility) could do if R1 left, so I said, you really can't provide that (supervision)."LG-C stated RN-B did not communicate well with her and CM-D, stating RN-B would update them days after R1 went missing.	02310		

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02310	Continued From page 6 On January 19, 2024, at 1:00 p.m., ULP-E stated R1 eloped "a lot," and needed someone with her when she was out in the community. ULP-E stated, "I've gone out with her once, and she liked that." ULP-E stated sometimes staff would call law enforcement when R1 left but stated, "you can't force her to stay." On January 22, 2024, at 1:30 p.m., CM-D stated nearly right away there were concerns about the facility. R1 did not understand risks and was "high risk" and vulnerable to abuse and self-abuse. CM-D stated there were times she and LG-C were unaware R1 was gone from the facility. On January 23, 2024, at 3:30 p.m., R1 stated she was able to come and go as she pleased, including the other residents. R1 stated, "they didn't do shit. They were supposed to do things, but they didn't. On January 24, 2024, at 12:00 p.m., RN-B stated residents who required 1:1 staff supervision in the community meant they were supposed to have staff with them at all times. RN-B stated she owned five facilities in the area and staffed one ULP per 12-hour shift in addition to three additional staff who "floated" between the five facilities between 7:00 a.m. and 7:00 p.m. RN-B stated the residents were aware of their rights, stating, "since they have rights you can't hold them back," The licensee policy titled, Missing Resident, dated April 1, 2023, indicated staff were to call the resident's emergency contact list to ask them if they took the resident out of the licensee's facility, and update the resident's representatives and case manager to keep them updated with steps taken to locate the resident.	02310		

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02310	Continued From page 7 TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for tag 2360.	