Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34360001M
Compliance #: HL34360002C

Date Concluded: December 1, 2022

Name, Address, and County of Licensee Investigated:
Capital Home Health Care LLC
3516 73rd Avenue North
Minneapolis Minnesota 55407
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, RN
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 perpetrator (AP) abused a resident when he punched him in the head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although facility administration reported observation of video footage of the AP hitting the resident, no video footage was available for review at the time of the onsite visit. The resident sustained no injury and the AP denied abusing the resident. Police were contacted at the time of the incident and no charges were filed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator conducted interviews with law enforcement, the resident's family and outside agency case workers. The investigation included an onsite visit with review of facility policies, procedures, resident records, employee files and staff training. In addition, the investigator reviewed the police report.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, anti-social personality disorder, traumatic brain injury, and intellectual disability. The resident's service plan included assistance with medication management and activities of daily living. The resident's assessment included a history of being physically and verbally aggressive and identified the resident was at risk to abuse other vulnerable adults.

During an interview, the licensed assisted living director (LALD) stated he received a call the day of the incident, from the alleged perpetrator (AP) at 7:40 a.m. The AP reported a verbal exchange occurred with the resident which escalated into a physical altercation.

The LALD later reviewed facility video footage and indicated he observed the resident and the AP arguing in the doorway of the resident's room, located on the lower level of the facility. The resident then rushed out of the room, swinging his arms, attempting to hit the AP. The AP backed up, in attempts to avoid contact with the resident, until he was stopped by the staircase. The AP then struck the resident with a fist, causing him to hit his head on the wall and fall to the ground. The AP exited the facility, contacted police and the resident returned to his room. When local police department officers arrived, the AP and the VA had separated. Police escorted the VA to the hospital for observation. The VA sustained no physical injuries.

During an interview, the AP indicated the resident became violent after being confronted over possessions observed in his room. The resident grabbed a knife and charged out of his room towards the AP and a physical confrontation ensued. The AP stated he did not make physical contact with the resident. The AP indicated when he was able to get away from the resident and exit the facility, he contacted police for assistance. The AP denied physically abusing the resident.

The police report identified that upon arrival to the facility, the AP and the resident had separated. There was no information in the police report which identified the AP abused the resident. Police evaluation of the resident determined the resident to be a possible threat to staff and himself and was taken to the hospital for evaluation. No charges were filed related to this incident.

During an interview, the resident's family member stated they were not aware of the incident and were not in frequent contact with the resident.

Multiple attempts to interview the resident were unsuccessful.

In conclusion, the Minnesota Department of Health determined abuse is 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: No, attempts to contact were unsuccessful.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility reported and investigated the incident. The facility provided additional training to staff in de-escalation techniques. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
None taken at this time.

You may also call 651-201-4890 to receive a copy via mail or email

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
	34360	A. BUILDING: _____ B. WING _____	C 08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL HOME HEALTH CARE LLC	3516 73RD AVENUE BROOKLYN CENTER, MN 55429

(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 Initial comments On August 29, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL34360002C/#HL34360001M. No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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.	