Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369073164M
Compliance #: HL369075192C

Date Concluded: May 3, 2023

Name, Address, and County of Licensee Investigated:
Cozy Baraka Home Care
3554 Boone Avenue N.
New Hope, MN 55427
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele R. Larson, RN
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 (resident #1) when he told the resident he would break the resident's legs and stick a plunger up the resident's rectum.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although resident #1 reported the incident to several people, he was inconsistent with what he reported. The AP denied the allegations. In addition, there were conflicting stories between family members and other residents on what happened. Multiple staff stated they were afraid of resident #1 because he was physically and verbally aggressive.

The investigator conducted interviews with facility staff members, former staff, unlicensed staff, and residents. The investigator interviewed family members and licensed health professionals. Resident #1, resident #2, and the AP were interviewed. The investigator interviewed law enforcement. The investigation included review of resident #1's record, hospital records, case

worker notes, and police reports. Also, the investigator observed the facility and residents during her onsite investigation

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included but was not limited to generalized anxiety disorder and major depressive disorder. Resident 1#'s service plan included assistance with behaviors. Resident 1#'s assessment indicated he was alert and oriented to person, place, and time. Resident #1 was vulnerable to being abused, abusing others, and to self-abuse.

Resident 1#'s law enforcement report indicated during the middle of the night, resident #1 contacted law enforcement to report an incident between the resident and the AP. The report indicated resident #1 woke up to smoke outside but left the door open. The AP was angry the door was left open. Resident #1 and the AP argued. Resident #1 used vulgar words towards the AP. Resident #1 told law enforcement the AP told resident #1 he would break resident 1#'s legs and would "use a plunger and use it on his rectum." Resident #1 cried as he told the story to law enforcement. The AP denied the accusations and indicated resident #1 was verbally aggressive towards him and disturbed the other two residents who resided in the facility (resident #2, resident #3). The AP indicated he contacted his supervisor and would file a report. Resident #1 agreed to stay in his room for the rest of the evening.

Resident #1's law enforcement reports indicated law enforcement were dispatched two additional times within a four-hour period related to disturbances caused by resident #1.

Resident #1's progress notes indicated during the middle of the night resident #1 called the owner to say the AP bothered him, but resident #1 would not say what the AP did to upset him. Resident #1 told the owner he planned to bother the AP the rest of the night until the AP's shift ended. In the morning, resident #1 met the owner outside the facility. Resident #1 yelled, swore, and using racial slurs about the AP. Resident 1#'s verbal aggression continued throughout the day until family member (FM) #2 took resident #1 back to their home to spend the night.

Resident 1#'s progress note indicated resident #1 initially never mentioned the alleged emotional and verbal abuse the AP used towards him.

Resident #1's progress notes indicated two days later resident #1 told the owner the AP told resident #1 to use a plunger to satisfy himself. Resident #1 indicated it reminded him of the sexual abuse he suffered as a child by another family member.

Review of resident #1's record indicated resident #1 reported the incident to several people, including licensed health professionals who then reported the incident to the adult abuse reporting center. Resident 1#'s version of what occurred varied with each person he told.

During an interview, resident (#2) stated he never heard the AP say anything sexual towards resident #1. Resident #2 stated he overheard the AP telling resident #1 to calm down or the AP would call the crisis center the night of the incident. Resident #2 stated resident #1 could be obnoxious at times.

During an interview, a law enforcement officer stated local law enforcement knew resident #1 years before the incident. The law enforcement officer stated calls regarding resident #1 increased, stating law enforcement were called to the facility 10 times in the month prior to the incident.

During an interview, an unlicensed staff member stated resident #1 had behavior issues and was often verbally aggressive to staff and residents, stating staff were afraid of resident #1. The unlicensed staff member recalled an incident when she ran and locked herself in a bathroom after resident #1 chased her. The unlicensed staff member stated resident #1 threatened resident #2 and resident #3, stating she overheard resident #1 telling resident #3 he would use his walker to break resident #3's legs so resident #3 would never be able to walk again. The unlicensed staff member stated the AP was a nice, gentle man who displayed no signs of aggression towards residents or other staff members.

During an interview, the owner stated the calls she received that night were about resident #1 and the AP were about the outside door. The owner stated she did not hear the details of the incident until the next day when the resident told her. The owner stated she terminated the AP's employment with the facility the day after the incident.

During an interview, resident #1's licensed health professional stated resident #1 told FM #1 the AP showed his private parts to resident #1, and stated resident #1 showered with his clothes on because he was afraid the AP would return to the facility.

During an interview, FM #1 stated she received a phone call from resident #1 the night of the incident. Resident #1 told her the AP threatened to break his legs and shove a plunger up his rectum. FM #1 stated she heard the AP in the background, laughing, yelling, and screaming at resident #1. FM #1 stated she overheard the AP telling resident #1 he would break his legs and use a plunger on resident #1. FM #1 stated resident #1 was a sweet, gentle, man who loved animals.

During an interview, resident #1 stated he woke up that night to drink milk and eat some cake. Resident #1 stated he went outside to smoke. Resident #1 asked resident #3 to leave the door open to let warm air outside because it was cold outside. Resident #1 stated the AP used the "F" word to both resident #1 and resident #3. Resident #1 stated he would immediately go and open the door whenever the AP closed it. Resident #1 stated he told the AP he paid rent and stated he told the AP he would call law enforcement and say the AP touched him. Resident #1 stated he got "fed up" with the AP so he went to his room and called FM #1. Resident #1 told FM #1 the AP being sexual with himself in front of resident #1. Resident #1 stated he ran to his

room and slammed the door. Resident #1 stated he called law enforcement after FM #1 told him to do so.

During an interview, the AP denied resident #1's allegations. The AP stated the resident would get mad if he did not get his way and would yell and scream at staff and used racial slurs. The AP stated resident #1 made false accusations during a meeting between the owner, FM #1, FM #2, and resident #1. The AP stated he wanted law enforcement to take resident #1 to the crisis center because he was so disruptive the night of the incident.

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" 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP no longer works at the facility.

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

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
	36907	A. BUILDING: _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	3554 BOONE AVENUE NORTH NEW HOPE, MN 55427

(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****** ASSISTED LIVING PROVIDER LICENSING 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: #HL369075192C/#HL369073164M On March 30, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 2 residents receiving services under the provider's Assisted Living Facility license. The following correction orders are issued for #HL369075192C/#HL369073164M, tag identification 620, and 3000.	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. No plan of correction is required for tag	

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0 000	Continued From page 1	0 000	2360. Please refer to the public maltreatment report for details.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of two residents (R2) with records reviewed. The licensee was aware of the incident but failed to immediately report the incident to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings Include: R2's record was reviewed. R2 admitted to the facility on April 5, 2021, during the time the previous licensee owned the facility. R2's diagnoses included generalized anxiety disorder and major depressive disorder.	0 620		

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0 620	Continued From page 2 R2's service plan dated April 5, 2021, indicated R2 received assistance with personal cares, housekeeping, laundry, ambulation/exercise, mobility/escort assistance, group socialization, medication administration/management, behaviors, shopping, and transportation. R2 used a wheeled walker, cane, and wheelchair for mobility. R2's assessment dated December 2, 2022, indicated R2 was alert and oriented to person, place, and time. R2 was verbally aggressive with staff when staff did not administer his pain medications when he requested them. Staff were to speak calmly to resident and to follow R2's physician orders when administering his medications. R2 did not wander from facility. R2 was independent with mobility and did not require staff escorts. R2 was at risk for falling due to unsteadiness and balance issues when he walked. Staff were to assist as needed. R2 was vulnerable to being abused, abusing others, and self-abuse. Staff were trained to report abuse and were to remove R2 if another resident became verbally aggressive. Staff were encouraged to notify the nurse whenever R2 made suicidal comments. R2's police report dated October 9, 2022, at 3:42 a.m., indicated R2 called law enforcement to report an issue he had with unlicensed personnel (ULP)-F. Upon arrival, R2 told law enforcement he stepped outside to smoke and left the outside door open. R2 indicated he and ULP-F argued about the door being open. R2 used vulgar words towards ULP-F during their argument. R2 indicated ULP-F told R2 he would break R2's legs and should, "go use a plunger and use it on his rectum." R2 cried when he told law enforcement.	0 620		

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0 620	Continued From page 3 ULP-F denied saying those words to R2, and indicated R2 used vulgar words towards him which caused a disturbance in the facility. ULP-F indicated he called owner (OW)-E about the incident. R2 agreed to stay in his room for the night. R2's police report dated October 9, 2022, at 4:19 a.m., indicated ULP-F called law enforcement back to the facility. ULP-F told law enforcement R2 would not stay in his room and indicated R2 threatened ULP-F with a spoon but was unable to explain how it would be used. R2 indicated he went to eat some yogurt and grabbed a spoon. ULP-F attempted to reach other staff members to work the rest of his shift but was unable to find a staff member to replace him so ULP-F went out to his vehicle until he was replaced by morning staff. ULP-F stated the residents could call him on his cell phone if they needed anything. ULP-F indicated he would resign and told law enforcement R2 abused the system and, "he could go out and get a job instead of abusing the system for money." R2's progress note dated October 9, 2022, at 3:23 p.m., indicated at 3:05 a.m., R2 called OW-E to complain about ULP-F. R2 told OW-E he would make sure to, "bother ULP-F all night long." At 7:00 a.m., OW-E arrived at the facility. R2 stepped outside and used racial slurs and obscenities towards OW-E and ULP-F. ULP-F left the premises but R2 continued to yell, swear, and use racial slurs towards OW-E and another ULP who worked. R2's progress note dated October 11, 2022, at 8:20 p.m., indicated at 5:10 p.m., OW-E met with R2, FM-A, and FM-C to discuss the events that occurred on October 9, 2022. OW-E informed	0 620		

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0 620	Continued From page 4 FM-A and FM-C that ULP-F would be on a leave-of-absence until the investigation was completed. OW-E informed FM-A and FM-C she would file a MAARC report regarding the incident, indicating she was a mandated reporter. OW-E indicated R2's incident was also reported to R2's Community Access for Disability Inclusion (CADI) case manager (CCM)-D. R2 apologized to OW-E indicated he did not want to move out because he liked living in the facility. The facility MAARC report was received on October 12, 2022, at 10:48 p.m. On April 25, 2022, at 11:15 a.m., OW-E stated she could not recall when the MAARC report was filed. A vulnerable adult policy was requested but not provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to	03000		

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03000	Continued From page 5 believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of	03000		

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03000	Continued From page 6 two residents (R2) with records reviewed. The licensee was aware of the incident but failed to immediately report the incident to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings Include: R2's record was reviewed. R2 admitted to the facility on April 5, 2021, during the time the previous licensee owned the facility. R2's diagnoses included generalized anxiety disorder and major depressive disorder. R2's service plan dated April 5, 2021, indicated R2 received assistance with personal cares, housekeeping, laundry, ambulation/exercise, mobility/escort assistance, group socialization, medication administration/management, behaviors, shopping, and transportation. R2 used a wheeled walker, cane, and wheelchair for mobility. R2's assessment dated December 2, 2022, indicated R2 was alert and oriented to person, place, and time. R2 was verbally aggressive with staff when staff did not administer his pain medications when he requested them. Staff were to speak calmly to resident and to follow R2's physician orders when administering his medications. R2 did not wander from facility. R2 was independent with mobility and did not require	03000		

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03000	Continued From page 7 staff escorts. R2 was at risk for falling due to unsteadiness and balance issues when he walked. Staff were to assist as needed. R2 was vulnerable to being abused, abusing others, and self-abuse. Staff were trained to report abuse and were to remove R2 if another resident became verbally aggressive. Staff were encouraged to notify the nurse whenever R2 made suicidal comments. R2's police report dated October 9, 2022, at 3:42 a.m., indicated R2 called law enforcement to report an issue he had with unlicensed personnel (ULP)-F. Upon arrival, R2 told law enforcement he stepped outside to smoke and left the outside door open. R2 indicated he and ULP-F argued about the door being open. R2 used vulgar words towards ULP-F during their argument. R2 indicated ULP-F told R2 he would break R2's legs and should, "go use a plunger and use it on his rectum." R2 cried when he told law enforcement. ULP-F denied saying those words to R2, and indicated R2 used vulgar words towards him which caused a disturbance in the facility. ULP-F indicated he called owner (OW)-E about the incident. R2 agreed to stay in his room for the night. R2's police report dated October 9, 2022, at 4:19 a.m., indicated ULP-F called law enforcement back to the facility. ULP-F told law enforcement R2 would not stay in his room and indicated R2 threatened ULP-F with a spoon but was unable to explain how it would be used. R2 indicated he went to eat some yogurt and grabbed a spoon. ULP-F attempted to reach other staff members to work the rest of his shift but was unable to find a staff member to replace him so ULP-F went out to his vehicle until he was replaced by morning staff. ULP-F stated the residents could call him	03000		

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03000	Continued From page 8 on his cell phone if they needed anything. ULP-F indicated he would resign and told law enforcement R2 abused the system and, "he could go out and get a job instead of abusing the system for money." R2's progress note dated October 9, 2022, at 3:23 p.m., indicated at 3:05 a.m., R2 called OW-E to complain about ULP-F. R2 told OW-E he would make sure to, "bother ULP-F all night long." At 7:00 a.m., OW-E arrived at the facility. R2 stepped outside and used racial slurs and obscenities towards OW-E and ULP-F. ULP-F left the premises but R2 continued to yell, swear, and use racial slurs towards OW-E and another ULP who worked. R2's progress note dated October 11, 2022, at 8:20 p.m., indicated at 5:10 p.m., OW-E met with R2, FM-A, and FM-C to discuss the events that occurred on October 9, 2022. OW-E informed FM-A and FM-C that ULP-F would be on a leave-of-absence until the investigation was completed. OW-E informed FM-A and FM-C she would file a MAARC report regarding the incident, indicating she was a mandated reporter. OW-E indicated R2's incident was also reported to R2's Community Access for Disability Inclusion (CADI) case manager (CCM)-D. R2 apologized to OW-E indicated he did not want to move out because he liked living in the facility. The facility MAARC report was received on October 12, 2022, at 10:48 p.m. On April 25, 2022, at 11:15 a.m., OW-E stated she could not recall when the MAARC report was filed. A vulnerable adult policy was requested but not	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36907	A. BUILDING: _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COZY BARAKA HOME CARE INC	3554 BOONE AVENUE NORTH NEW HOPE, MN 55427

(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
03000	Continued From page 9 provided. TIME PERIOD TO CORRECT: Seven (7) days.	03000		