Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL379531141M
Compliance #: HL379531323C

Date Concluded: August 22, 2025

Name, Address, and County of Licensee Investigated:

Victory Homes
7917 Perry Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Not Substantiated

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 medication errors were made, causing the resident to hallucinate and require a visit to the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident's medication administration record (MAR) indicated the resident did not receive olanzapine, psychotropic medication, due to it not being available, the medication was not available due to the resident's provider declining to renew the prescription when the resident's refused to complete a medical appointment with the provider. The facility continued to offer and provided the resident's medication as ordered, despite the resident's adamant refusals to take medications at times. The facility continued to schedule and transport the resident to medical appointments as needed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker and a family member. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions and cares.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, anxiety, bipolar disorder and borderline personality disorder. The resident's service plan included assistance with behavior management, medication administration and safety checks. The resident's assessment indicated the resident needed help taking medication and was non-compliant with taking medications. The assessment indicated the resident walked independently, was intermittently disoriented to person, place and time, and could be verbally and physically aggressive.

The resident's care plan indicated the resident had history of refusing her olanzapine medication. Staff provided encouragement and reapproached the resident in attempt to have medication compliance. The care plan indicated the resident's provider was updated regarding the resident's medication refusals, and the resident refused to meet with the provider for an appointment.

The resident's medication administration record indicated the resident did not receive her psychotropic medication, olanzapine, for ten consecutive days. The staff documented the resident did not receive the medication due to it not being available.

The resident's progress notes indicated the resident had multiple incidents of verbal outburst with refusals of medications and other cares such as obtaining her weight, allowing staff to assist with laundry, and housekeeping services. The notes documented multiple episodes of the resident talking to herself and making delusional statements related to hallucinations had. The notes indicated the resident called law enforcement and reported staff kidnapped her from other countries, and law enforcement transported the resident to the emergency room for evaluation.

The resident's emergency room evaluation notes indicated the resident was alert and oriented to person, place and time. The notes indicated the resident endorsed symptoms of depression and denied symptoms of anxiety, bipolar disorder, and psychosis. The notes indicated the resident did not require an acute psychiatric admission and her needs could be met in the community. The resident was returned to the facility.

An email from the resident's case manager indicated the resident was historically not compliant with her medications.

During an interview, unlicensed personnel (ULP) stated every time she worked with the resident, the resident's medications were available. The ULP stated the resident always refused

her medication and would state nobody could make her take it. The ULP stated the resident continued to refuse her medication after multiple attempts. The ULP stated the resident began to talk to herself and say she had no family when she did not take her medication regularly.

During an interview, a facility manager stated the nurse was responsible for ensuring the resident's medications were available, and if a medication was not available, staff notify the nurse. The manager stated there have been times the resident's medication ran out because the resident refused to see the provider, so the provider would not renew the prescription. The manager stated staff were trained to talk to the resident multiple times when she refused her medication to try to get her to take them, but that it never worked.

During an interview, the nurse stated staff called her when the resident refused her medication, and she attempted to speak to the resident over the phone, but the resident refused to speak to her. The nurse stated she notified the resident's provider of the resident's refusals, and the provider indicated the resident had the right to refuse. The nurse stated the resident sometimes went without her medication when the resident refused to see the prescribing provider. The nurse stated she found a new provider to obtain the prescriptions from. The nurse stated they attempted to change the medication administration time, have the resident's family speak with her, and have medications changed to injectable form in attempt to improve the resident's medication compliance.

During an interview, the resident stated the facility ran out of her medications a couple of times due to problems with getting into a psychiatry appointment, and appointments being cancelled over and over. The resident stated she went to the emergency room and was not sure why, that it may have been due to having leukemia.

During an interview, a family member stated the resident was not a reliable reporter because she took herself off her medication. The family member stated the resident was compliant with her medications at times, and then not at all compliant other times. The family member stated he believed when the resident takes her medication, she becomes stable and then thinks she does not need the medication anymore and stops taking them. The family member stated the staff should recommend the medication to the resident, keep trying to get her to take them, and have her go to a medical facility if they are concerned about her not taking her medication.

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

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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.
(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility updated the resident’s provider of her medication refusals and encouraged the resident to take her medication as prescribed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37953	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HOMES	7917 PERRY AVENUE NORTH BROOKLYN PARK, MN 55443

(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 16, 2025, the Minnesota Department of Health initiated an investigation of complaint HL379531323C/HL379531141M. No correction orders are issued.	0 000		