Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL263231603M
Compliance #: HL263239167C

Date Concluded: July 25, 2024

Name, Address, and County of Licensee Investigated:
Empowerment Healthcare
7517 69th Ave. North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 the facility failed to provide appropriate supervision resulting in the resident drinking alcohol and using methamphetamines, causing him to become physically combative, resulting in destruction of property and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the incident occurred, staff followed the resident's care plan, attempted de-escalation interventions, and contacted the police. The resident was hospitalized and returned to the facility.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator also contacted the resident's case worker. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, staff schedules, law enforcement reports, and related

facility policies and procedures. At the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included a history of polysubstance abuse and traumatic brain injury (TBI). The resident's care plan included assistance with medication and behavioral management. The resident's assessment indicated the resident had a history of verbal and physical aggression.

The resident's medical record indicated the resident threatened staff several times in the days prior to the incident and experienced an increase in agitation when intoxicated. Facility staff attempted interventions to provide a calm and safe environment, avoided confrontation, listened, and acknowledged concerns, redirected the resident, and completed safety checks every two hours. When interventions were not successful, staff notified the facility nurse.

An incident report indicated the resident attempted to obtain a cigarette from another resident and when staff provided redirection to the resident, he chased the staff member out of the facility with a brick. The resident smashed the brick into the staff member's car windshield. Facility management, nursing staff, and 911 were immediately contacted.

The police report indicated the resident was intoxicated, destroyed property, threatened staff, threw a screwdriver, and attempted to choke another resident at the time of the incident. The police officers felt the resident posed a threat to others and brought the resident to the hospital for further evaluation.

The hospital report indicated the resident was seen for agitation and aggression. The resident told the hospital staff he had been drinking alcohol all day and taking methamphetamines. The resident returned to the facility eight hours after the incident.

During an interview, staff working at the time of the incident stated they attempted to redirect the resident from banging on the doors, when the resident turned his aggression towards them and became physically aggressive. Staff were chased by the resident and ran two blocks away and the police were notified. When staff returned, a windshield was broken out of one of the vehicles. Police arrived, the resident was brought to the emergency room and later returned to the facility.

During an interview, the facility nurse stated no alcohol or drugs were allowed in the facility, but the resident was able to independently leave the facility and when he left, he drank. The resident refused to establish care with a medical provider and fired his case worker. The facility nurse stated staff was limited on interventions and calling police was the only option available to keep everyone safe.

During an interview, facility management stated that prior to the incident, a pretermination meeting was held with the resident regarding his behaviors and they planned to evict the

resident in 60 days. After the pretermination meeting, the resident stated he had nothing to lose if he was evicted and that he would take everyone down with him. The resident started smoking in the facility, intentionally left burners on, drank alcohol and took methamphetamines. After the incident, the facility increased staffing and implemented additional safety checks on all residents out of fear of the resident. The resident later discharged from the facility after an incident that resulted in an arrest.

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.

Vulnerable Adult interviewed: No; resident unavailable for interview
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called 911 and the resident was taken to the hospital. After the incident, the facility hired additional staff for each shift and increased safety checks for all residents.

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
	26323	A. BUILDING: _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPOWERMENT HEALTHCARE	7517 69TH AVENUE NORTH BROOKLYN PARK, MN 55428

(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 June 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL263239167C/#HL263231603M. No correction orders are issued.	0 000		