Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL345265362M
Compliance #: HL345262480C

Date Concluded: November 25, 2025

Name, Address, and County of Licensee Investigated:

Empire Systems Home Care
6012 York Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck,
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 they failed to provide adequate food, wound care, hygiene, or transportation which resulted in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided food, cares, and transportation as the resident allowed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and family. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included opioid use disorder, anxiety, and pressure ulcers. The resident's service plan included assistance with activities of daily living, bed baths, dressing, hygiene, meal preparation, medication administration, cleansing of skin after resident used a urinal or had bowel movement, behavioral interventions, and housekeeping. The resident's assessment indicated the resident chose to remain in bed and refused to allow staff to clean his room, remove uneaten food, turn/reposition him, transfer him to his wheelchair, or leave the house; stating he would not leave his bed until he had his leg amputated, which had not been planned.

Several incident reports indicated the resident became verbally abusive and threw things at staff after the resident had visitors, with suspicions of drug use.

One incident report indicated a staff found a syringe and drug paraphernalia in the resident's bedding.

During an interview, the staff stated he found a syringe with some liquid remaining inside and a rubber tourniquet. The staff stated the resident became significantly more aggressive towards staff after the items were discovered.

An incident report indicated one day the resident called 911 without staff knowledge. The report indicated emergency medical services arrived and brought the resident to his preferred hospital.

Hospital records indicated the resident was admitted for complaints of left leg pain and right flank cellulitis. Hospital records indicated the resident received an above the knee amputation of his left leg about two weeks after admission and started Suboxone (a prescription medication used to treat opioid addiction). Hospital records indicated the resident had prior hospitalizations where staff found drug paraphernalia in his room and required visitor restrictions due to visitors bringing in drugs.

During an interview, a nurse stated the resident was initially cooperative but became resistive to staff assistance. The nurse stated staff reported the resident was verbally abusive and would throw food at staff. The nurse stated the resident frequently demanded double portions of meals and would not allow staff to clean up his room.

During investigative interviews, multiple staff members stated the resident was initially cooperative with cares, but as time went on became secretive with visitors, verbally and physically abusive to staff, refused medications, refused to allow staff to clean his room, and refused to get out of bed, despite having a mechanical lift and bariatric wheelchair available for his use.

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, the resident did not respond to requests for an interview.
Family/Responsible Party interviewed: No, family did not respond to requests for an interview.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility made changes to the resident’s care plan, providing staff with interventions to use when the resident was refusing services and/or was verbally and physically abusive.

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
	34526	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPIRE SYSTEMS HOME CARE	6012 YORK AVENUE NORTH 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 On November 4, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL345262480C/#HL345265362M. No correction orders are issued.	0 000		