Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373221360M
Compliance #: HL373221962C

Date Concluded: June 17, 2025

Name, Address, and County of Licensee Investigated:
Bright Path Homes
6600 Central Avenue NE
Fridley, MN, 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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), a staff member, physically abused the resident when responding to the resident striking out at the AP. The AP roughly transferred the resident into bed causing the resident's old skin wound injury to reopen and caused a new skin wound injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting reports between an unlicensed personnel and the AP of the incident and how the resident's transfer occurred. The AP denied causing the skin tear. While the resident did sustain a new skin tear on the back of her leg, there was not a preponderance of evidence to support the AP's actions did or did not cause this. There were no cameras in the resident's room.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed personnel, and the AP. The investigator contacted law enforcement. The investigation included review of the resident records, facility internal investigation, facility

incident reports, personnel file, and related facility policy and procedures. Also, the investigator observed the facility.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, intellectual disability with behavior dyscontrol (impaired ability to resist impulses.) The resident's service plan included as needed staff stand by assist with transfers using a walker. The resident used a wheelchair for long distances. The resident required assistance with managing the resident's agitation, verbal and physical aggression. The resident required staff assist to stand from a sitting position and required as needed stand by assist with transfers. The resident was disoriented to place, time, and had a memory problem. The resident's weight was 170 pounds.

The unlicensed personnel's incident report indicated the resident had pushed the AP. In response, the AP grabbed the resident, threw her into bed, and grabbed her legs with force while putting them into the bed which opened a previous wound on the resident's forearm and a new wound behind the resident's leg.

The AP's incident report indicated the resident had struck out at the AP when the AP attempted to put the resident to bed. Both staff noticed the new leg wound and asked the resident what happened, and the resident said the AP caused it. The AP documented that the resident had lied.

The facility internal investigation indicated the resident had a history of noncompliance with cares, verbal and physical "attacks" on staff, and falls. The resident had both physical and verbal aggressions. It was reported the resident sustained a new skin tear on her leg which was not a result of a previous fall.

During the facility investigation, an unlicensed personnel stated the AP told him the resident declined going to bed during the AP's shift and the AP was waiting for the unlicensed personnel to arrive to assist. At 11:30 p.m., the unlicensed personnel stated they both went into the resident's room. The resident was seated in her wheelchair. The AP pushed the resident "aggressively" in the wheelchair, and the resident struck out attempting to hit the AP. The AP lifted the resident out of the wheelchair and pushed the resident into bed. The AP pulled the resident's legs into bed "aggressively."

During the facility investigation, the AP stated while attempting to get the resident into bed, the resident swung and hit the AP. The resident used her feet and arms against the AP. While the AP attempted to finish the task of getting the resident into bed, the resident attempted to kick the AP. The AP attempted to position the resident toward the top of the bed to prevent the resident's feet from hanging off the bed. The AP covered the resident with a blanket and left the resident's room.

During the facility investigation, the resident stated that she, the resident, hit the AP. The AP got mad, moved the resident's legs, and her legs hit on the wheelchair causing a leg wound. The resident also stated she, the resident, called law enforcement because the AP "slapped" her all over the place.

Law enforcement stated there were no reports involving the AP and the resident or any other named staff member and the resident.

During an interview, an unlicensed personnel stated he was in front of the resident and asked the resident to hold onto his hands to stand up from the wheelchair to allow the resident to help with the transfer. The AP was behind the resident. The unlicensed personnel stated the AP grabbed the resident from behind by the waist and tossed the resident into bed. The AP then threw the resident's legs into bed. Afterwards, the unlicensed personnel noticed there was a new skin tear on the resident's leg and her forearm wound started to "leak." The unlicensed personnel stated the resident had a history of skin tears on her arms and previously on her legs. The unlicensed personnel stated the resident was aggressive towards staff and would strike out at staff.

During an interview, the AP stated during a transfer, the resident was in the wheelchair, and the wheelchair was brought closer to the bed. The AP and the unlicensed personnel were on either side of the resident and assisted the resident to stand by holding onto the resident's shoulders to stand up, the resident was able to stand. The resident then sat on the bed. Once the resident sat on the bed, the resident was assisted toward the top of the bed. The AP put the resident's legs into bed. The resident kicked the AP with her foot. During the task, the resident had struck out at the AP and kicked at the AP. The AP said the resident already had skin wounds and denied causing a new skin tear. The AP said herself and the unlicensed personnel had a history of work conflict with each other. During the cares and while in the resident's room, an argument between the AP and unlicensed personnel ensued when the unlicensed personnel told the AP she was rough with the resident.

During an interview, a nurse stated the resident was oriented to person, place, however she was disoriented to time and situation and was not able to recall exactly how things occurred. The resident provided bits and pieces of information when she communicated. The resident had a history of striking out physically at staff during cares. The resident had a history of these types of skin tears and abrasions from bumping her arms into doorway frames, bumping into items in her room, striking out at things, and striking out at staff. The resident's skin was fragile, thin, and bruised easily. The nurse stated the unlicensed personnel reported the AP was in a hurry at the end of her shift and had been forceful with the resident when putting the resident into bed. The following morning, the nurse stated she assessed the resident's skin and noticed a new skin tear on the lower back portion of the resident's right leg, just above the ankle, the size of a quarter. The nurse stated based on the location, the nurse felt the resident's foot/leg may have hit the bedframe when the resident was transferred from her wheelchair into bed. The nurse stated when asked, the resident said her night was "OK" however the "girl" working was rough.

The resident did not say the AP hurt her; the resident kept repeating she was rough with her. The nurse stated when asked the AP denied roughly handling the resident and denied causing the leg skin tear. The nurse stated the AP had worked with the resident before and there had been no other reports of concern from the resident or from other staff regarding the AP's interactions with the resident.

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: 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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No. Unable to be reached.
Family/Responsible Party interviewed: No. Family member was not identified.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted on internal investigation. The AP no longer worked at the facility the resident resided in.

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
	37322	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6600 CENTRAL AVENUE NE FRIDLEY, MN 55432

(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 May 7, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL373221962C/#HL373221360M. No correction orders are issued.	0 000		