Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL33179002M
Compliance #: HL33179003C

Date Concluded: October 2, 2020

Name, Address, and County of Facility Investigated:
Joyful Home Health Care, LLC.
5737 Regent Ave North
Crystal, MN 55429
Hennepin County

Name, Address, and County of Housing with Services location:
Joyful Home Health Care, LLC.
6568 Central Avenue NE
Fridley, MN 55432
Anoka County

Facility Type: Home Care Provider

Investigator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
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.

Allegation:
It is alleged: The facility neglected to ensure the client took his medications, and neglected to implement interventions when the client did not follow the leave of absence contract that was in place for medications.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the neglect. Both the facility and the AP were responsible to oversee the administration and coordination of the client's medication services. The AP neglected to monitor and reassess the client's medication management services when the client continued a pattern of missing his scheduled antipsychotic and antidepressant medications, and the interventions were ineffective. In addition, there was no evidence that the psychiatric provider was updated during the time when the number of missed doses of prescribed medications escalated. The facility did not have a process to provide oversight of the AP's responsibilities.

The investigation included interviews with licensed and unlicensed home care staff. The home care policies and procedures were reviewed as well as the client's record. The client's court documents and hospital records were also reviewed. The client's psychiatric health care providers were interviewed.

Review of the client's record indicated the client had a history of schizophrenia, psychosis, major depression, physical, verbal aggression, and substance abuse disorder. The client discharged from an inpatient psychiatric facility on a civil commitment provisional discharge and admitted to the facility. Review of the discharge summary indicated goals of treatment included; continue to work with and follow the outpatient psychiatric provider's recommendations, continue to take medications, and abstain from using drugs or alcohol.

Review of the provisional discharge plan indicated the conditions included taking medications as prescribed and maintaining safety and wellbeing, including not doing things to harm or threaten to harm self or another person.

The client's care plan and home care services included taking daily antipsychotic and antidepressant medications as ordered, attending psychiatry appointments, behavior monitoring, sleep monitoring, meals, and reminders with hygiene. Physician orders included medications to treat schizophrenia, delusions, and other psychoses. Orders also included independent leave of absence (LOA) with medications. Medications were sent with the client for planned times away.

The client's vulnerability assessment indicated the client had a history of illegal drug use, which worsened psychosis symptoms. The Mini-Mental State Examination (MMSE) on admission to the home care indicated the client had a score consistent with severe cognitive impairment.

Review of the client's baseline medication assessment indicated the AP managed the client's medication. The assessment indicated the AP would coordinate with the client's healthcare team to ensure adequate administration of all medications. Medication administration interventions included placing calls to the client, reminding the client to come back from outings for his medications, and educating the client on the importance of the medications.

Review of the client's medication administration records indicated, nearly each month, the client missed multiple days of his antipsychotic and antidepressant medications. During the month of July he missed 7 days, August was 7 days, September was 11 days, October no missed medication, November was 6 days, December was 16 days, January was 22 days, and February was 7 days, totaling 76 days of missed medication.

Review of the nursing progress notes and unlicensed staff care notes indicated the client missed his prescribed antipsychotic and antidepressant medications and some psychiatric and medical appointments when he did not return from planned and unplanned outings from the facility. The notes indicated the staff tried to reach the client via his cell phone, family member, or girlfriend to remind him to come back to the facility for his medications. Over the course of the client's 10-month stay at the facility, there was a two-month period where the number of missed medications increased and the client was arrested and jailed. As a result, the client, the AP, and case managers met to review goals of care and develop a contract to reinforce taking medications as prescribed. The client could go out on specified overnight outings with his medications with the expectation to return the following day. Progress notes indicated that after the meeting, the client continued to miss medications when he did not return after outings from the facility.

Review of the Recommitment Hearing document indicated that shortly after the contract was in place, the recommitment order was due for review. The client continued to meet the statutory criteria for civil commitment and the order was renewed for another twelve months.

The client's progress notes indicated that just days after the recommitment hearing, the AP received a phone call that the client was in jail.

Review of the client's hospitalization notes indicated the client was hospitalized with a diagnosis of drug induced psychoses following a homicide.

During interview with unlicensed staff, the client was called if he was not at the facility when his medications were due.

During an interview, the AP stated interventions included calling the client to remind him of his medications, and educating the client regarding the importance of taking his medications and the civil commitment order. She stated the client did not show any violent behavior at any time at the facility and thus believed the interventions in place were working. She stated it was not a locked facility and staff could not stop the client from going on outings. After the commitment order was renewed, the client was re-assessed, and the current care plan was continued. She stated there was not a formal communication plan with team members when the client did not comply with the provisions but the psychiatrist was contacted when the client had missed medications and an order to consolidate meds to administering one time per day had been requested.

During an interview, the client's psychiatry provider stated that she knew only of a two-week period where the client was away from the facility and did not receive his medications. When given the information that the client had missed a number of medications in addition to the two week period, she stated she was not aware and that was concerning. The client's medical records did not contain communication from the facility regarding other patterns of missed medications or the request to consolidate medication times. At the most recent psychiatry provider visit, there were no complaints of behavioral symptoms, but the client was referred to outpatient chemical dependency treatment and it was not known who made the referral.

During an interview, the supervising psychiatrist stated that if they had known the client missed doses of daily antipsychotic medication, a long acting injectable dose may have helped with his adherence. He further stated that usually within a couple of weeks of getting back on medications, regularly, the expectation would be that efficacy would be reached.

Review of the medication administration records indicated that the client did not receive his medications, regularly, for any two-week period over the last three months at the facility. He missed 16 days of medication in December, 22 days of medication in January, and 7 days of medication in February.

The client's county case manager team members declined the request for an interview.

In conclusion, neglect is substantiated. The AP neglected to monitor and reassess the client's medication management services when the client missed his medications when he did not return from outings away from the facility, and the interventions in place were not updated when shown to be ineffective. Also,

the AP failed to update the psychiatric provider the extent of missed medications. The facility did not have an assurance process to provide oversight for the AP's responsibilities.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Unable to reach for interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Anoka City Attorney
Anoka City Police Department
The Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33179	A. BUILDING: _____ B. WING _____	C 06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HOME HEALTH CARE LLC	5737 REGENT AVENUE NORTH CRYSTAL, 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 ******ATTENTION****** AMENDED OCTOBER 2, 2020 FOR ORDERS ISSUED HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On June 8, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL33179002M/#HL33179003C. At the time of the investigation, there were #4 clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL33179002M/#HL33179003C, tag identification 0325, 0910, AND 0935.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under	0 325		

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0 325	Continued From page 1 chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected when the facility did not monitor and reassess the clients medication administration when the client continued a pattern of missing his scheduled antipsychotic and antidepressant medications. In additions, the facility did not C1's psychiatry provider of C1's missed medications when he did not return to the facility after leave of absences or unplanned outings. Findings include: On August 26, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and alleged perpetrator were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) is required. Refer to the maltreatment public report for details.	
0 910 SS=G	144A.4792, Subd. 3 Individualized Medication Monitoring/Reassess Subd. 3.Individualized medication monitoring and	0 910		

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0 910	Continued From page 2 reassessment. The comprehensive home care provider must monitor and reassess the client's medication management services as needed under subdivision 2 when the client presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to the monitor and adequately reassess the efficacy of medications when providing mental health services for one of one clients (C1) reviewed for medication management services. C1 refused to return to the facility after multiple leaves of absence, had an increase of medication noncompliance, and continued to miss his antipsychotic and depression medications. C1 missed 76 daily medication administrations from July 2019 to February 2020 to manage his mental illness. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's hospital discharge from a psychiatric treatment facility summary dated May 1, 2019, indicated C1's progress toward treatment goal and recommendations for follow-up were to	0 910		

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0 910	Continued From page 3 continue to work with the outpatient psychiatric provider, follow his/her recommendations, continue to take medications, and abstain from using drugs and alcohol. C1's Civil Commitment Provisional Discharge paperwork dated May 1, 2019, indicated conditions for C1's discharge included taking his medications as prescribed. C1's admission indicated C1 moved into the facility on May 2, 2019, with diagnoses that included but not limited to, schizophrenia, substance abuse disorder, psychosis, and major depression. Medication assessment dated May 2, 2019, indicated C1 had a history of non-compliance, took medications inappropriately, missed doses, took excessive amounts, and misplaced medications. C1 required nurse and staff assistance with medications daily. Care plan document dated May 6, 2019, revision date of February 10, 2020, indicated C1 received services from the licensee that included medication management. Goals of care were to maintain stability, dignity and assure safety. The care plan indicated that C1's mental health treatment included psychotropic medications which were managed by his psychiatrist and staff were to ensure that C1 took his antidepressant and other medications as directed. Medication orders dated May 28, 2019 included: Haloperidol 7.5 milligrams (mg) at bedtime for schizophrenia. Trazadone 150 mg at bedtime for major depression. Loratidine 10 mg at bedtime for allergy. Atorvastatin 10 mg daily for dyslipidemia. Sertraline 50 mg once daily for	0 910		

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0 910	Continued From page 4 depression. Benztropine 0.5 mg twice daily as needed for schizophrenia. The monthly medication administration records (MARs) were reviewed. Review of the May 2019 MAR indicated C1 received all his prescribed medications. Review of the June 2019 MAR, indicated C1 did not return to the facility on June 11, as C1 was in police custody and did not receive his medications. The MAR indicted C1 was in jail through the rest of the month. Review of the July 2019 MAR indicated C1 returned to the facility on July 3 and missed medications on July 4 when he did not return from an outing. Medications were also missed July 18, 21, 22 and 29-31. Review of the August 2019 MAR indicated C1 missed medications on August 2, 3, 24, 25, 26, 27 and 28. Review of the September 2019 MAR indicated C1 missed medications on September 1, 3, 8, 9, 11-13, 15, 23, 26, and 27. Review of the October 2019 MAR indicated no medications were missed. A corresponding unlicensed staff progress note was not received for comparison. Review of the November 2019 MAR indicated C1 missed medications on November 11, 12, 17, 18, 24, 30. Review of the December 2019 MAR indicated C1 missed medications on December 1-5, 8, 10, 12-15, 19, 21, 22, 24, 25, 28, 30, 31. Review of the January 2020 MAR indicated C1 missed medications on January 1, 4, 5, 7-22, 26-28. Review of the February 2020 MAR indicated C1 missed medications on February 3, 7, 10, 16-17, 25-26	0 910		

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0 910	Continued From page 5 The medication reconciliation dated October 12, 2019, indicated the registered nurse (RN) to coordinate with client's health care team to ensure adequate administration of all medications. The medication reconciliation updated January 25, 2020, lacked updates although C1 had missed 41 days of his medication. A medication reassessment updated January 25, 2020, indicated C1's functional limitations included mental and intellectual disability. The assessment indicated the projected time frame away from the facility consisted of an overnight LOA on Tuesday and Friday. Staff were to pack the medications while on LOA, trips were generally planned and a medication plan was needed when the client was away from home. The reassessment lacked updates to the plan when C1 was non-compliant with returning to the home for his medications, or plan for communication to the physician when medications were missed. From July 2019 to January 25, 2020 C1 missed 66 days of his medication. Individual Abuse Prevention Plan dated February 10, 2020, indicated C1 required assistance with medication management and administration. C1 may refuse to take his medications as prescribed evidenced by leaving on LOA without medication and sometimes thinks he doesn't need the medications. C1 continued to be on Civil Commitment to take his antipsychotic medication Haldol. C1 was susceptible to abuse, injurious behaviors evidenced by not following his medication and treatment as ordered and at risk to use illegal drugs with prescribed medication. Staff were to remind C1 of the physician's orders	0 910		

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0 910	Continued From page 6 and educate as needed. During interview on June 15, 2020, at 11:04 a.m., Registered Nurse (RN)-A stated C1's case manager was "always kept in the loop." She stated that C1 took off for many days without his medication, he was called on the phone and he promised to come back but would not show up. Text messages were sent to the girlfriend as well, telling her the consequences of C1 not getting his medications and not being overseen by staff. During interview on August 11, 2020 at 2:12 p.m., physician assistant (PA)-F stated she was made aware of the missed medications during the two-week period in January at C1's February appointment. PA-F stated she was unaware of the high frequency that C1 missed his medications during December and January, and this was concerning. PA-F stated there was no record that the facility contacted the psychiatrist office regarding missed medications or the request to consolidate medications. During interview on August 13, 2020 at 2:00 p.m., RN-A was again asked to provide documentation for interventions put into place after C1 missed medications and did not return from LOAs. RN-A stated that she notified the case manager, family members and the psychiatrist office by phone about C1's behaviors and leaving without medications and at the psychiatrist appointments. One intervention was to call C1's phone to see how he was doing and remind him to come home. The contract dated January 23, 2020 was initiated as an intervention to see if that would improve his compliance, the copy of that contract was placed in his folder for staff to remind him about the contracts and things for him to follow.	0 910		

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0 910	Continued From page 7 Policy titled Assessment for Medication Management Program, dated August 25, 2019, indicated an assessment for non-adherence with drug therapy was to be performed. Based on the results of the assessment, the clinician will document an individualized medication management plan that included procedures for notifying the licensed health profession regarding problems arising with medication management services. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 910		
0 935 SS=G	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8.Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to complete administration for	0 935		

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0 935	Continued From page 8 antipsychotic and antidepressant medications as prescribed and document any follow-up procedures that were provided for one of one clients (C1) to meet the client's needs when medication was not administered as prescribed. The lack to medication administration and follow-up procedures contributed to 76 days of that C1 did not receive medication for the treatment of C1's mental health. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's discharge summary dated May 1, 2019, indicated C1's progress toward treatment goal and recommendations for follow-up were to continue to work with the outpatient psychiatric provider, follow his/her recommendations, continue to take medications, and abstain from using drugs and alcohol. C1's Civil Commitment Provisional Discharge paperwork dated May 1, 2019, indicated conditions for C1's discharge included taking his medications as prescribed. C1 moved into the facility on May 2, 2019, with diagnoses that included but not limited to, schizophrenia, substance abuse disorder, psychosis, and major depression.	0 935		

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0 935	Continued From page 9 Medication assessment dated May 2, 2019, indicated C1 had a history of non-compliance, took medications inappropriately, missed doses, took excessive amounts, and misplaced meds. C1 required nurse & staff assistance with medications daily. Care plan document dated May 6, 2019, revision date of February 10, 2020, indicated C1 received services from the licensee that included medication management. Goals of care were to maintain stability, dignity and assure safety. The care plan indicated that C1's mental health treatment included psychotropic medications which were managed by his psychiatrist and staff were to ensure that C1 took his antidepressant and other medications as directed. Review of the physician orders for medications dated May 28, 2019 were for the following: Haloperidol 7.5 milligrams (mg) at bedtime for schizophrenia. Trazadone 150 mg at bedtime for major depression. Loratidine 10 mg at bedtime for allergy. Atorvastatin 10 mg daily for dyslipidemia. Sertraline 50 mg once daily for depression. Benztropine 0.5 mg twice daily as needed for schizophrenia. The monthly medication administration records (MARs) were reviewed as well as the corresponding unlicensed person (ULP) staff shift notes. Review of the May 2019 MAR indicated C1 received all his prescribed medications. Review of the June 2019 MAR, indicated C1 did not return to the facility on June 11, as C1 was in police custody and did not receive his medications. The MAR indicted C1 was in jail through the rest of the month. Review of the July 2019 MAR indicated C1	0 935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33179	A. BUILDING: _____ B. WING _____	C 06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HOME HEALTH CARE LLC	5737 REGENT AVENUE NORTH CRYSTAL, MN 55429

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0 935	Continued From page 10 returned to the facility on July 3 and missed medications on July 4 when he did not return from an outing. Medications were also missed July 18, 21, 22 and 29-31. Review of the August 2019 MAR indicated C1 missed medications on August 2, 3, 24, 25, 26, 27 and 28. Review of the September 2019 MAR indicated C1 missed medications on September 1, 3, 8, 9, 11-13, 15, 23, 26, and 27. Review of the October 2019 MAR indicated no medications were missed. A corresponding unlicensed staff progress note was not received for comparison. Review of the November 2019 MAR indicated C1 missed medications on November 11, 12, 17, 18, 24, 30. Review of the December 2019 MAR indicated C1 missed medications on December 1-5, 8, 10, 12-15, 19, 21, 22, 24, 25, 28, 30, 31. Review of the January 2020 MAR indicated C1 missed medications on January 1, 4, 5, 7-22, 26-28. Review of the February 2020 MAR indicated C1 missed medications on February 3, 7, 10, 16-17, 25-26. A review of the shift notes for C1 lacked documentation that the RN was not notified each time the client missed his medications. A review of C1's progress notes documented by the RN lacked documentation that any updated medication management plan was employed as a result of C1 missing medications, or that the psychiatric provider was contacted. During interview on June 10, 2020, at 1:36 p.m., unlicensed staff person (ULP)-B stated staff would call and call and call C1, asking when he would be home and he would say soon or on his	0 935		

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0 935	Continued From page 11 way. During interview on June 10, 2020 at 3:03 p.m., ULP-C stated when C1 didn't return, they would call his girlfriend. They always documented it and called the nurse supervisor. During interview on June 15, 2020, at 11:04 a.m., Registered Nurse (RN)-A stated C1 took off for many days without his medication. C1 was called on the phone and he promised to come back but did not show up. Policy titled Assessment for Medication Management Program, dated August 25, 2019, indicated the assessment for non-adherence with drug therapy was to be performed. Based on the results of the assessment, the clinician will document an individualized medication management plan that included procedures for notifying the licensed health profession regarding problems arising with medication management services. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 935		