

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL353076882M
Compliance #: HL353071421C

Date Concluded: April 2, 2025

Name, Address, and County of Licensee

Investigated:

Grace Hand Group
1523 Girard Ave North
Minneapolis, MN 55411
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, individual responsibility

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) neglected a resident when the AP did not provide staff to supervise a resident who was placed in a hotel room before placement at a new facility. The resident was left on his own and unsupervised for five days even though he had multiple vulnerabilities that required supervision creating an unsafe situation for the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP placed the resident in a hotel room where he was left on his own and unsupervised for five days even though he had multiple vulnerabilities that placed him in an unsafe situation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the case worker. The

investigation included review of resident and employee records, and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, bipolar disorder, major depression with severe psychotic symptoms, cannabis and alcohol abuse, and post-traumatic stress disorder. The resident's service plan included assistance with behavior management four times a day, grooming assistance, safety checks four times a day, socialization three times a day, and vital signs once a week.

The resident's assessment indicated the resident was self-administering his medications, however, was vulnerable in the following areas: needed reminders to take the medications, needed help with topical medications, needed reminders for grooming and hygiene, needed daily housekeeping, and laundry service. The resident also had a history of drug and alcohol use requiring 24-hour supervision, paranoia, and depression, and staff were directed to report any concerns to the nurse.

The resident's vulnerability assessment indicated the resident required 24-hour staff. Staff were to monitor for behaviors that threatened the resident's safety and safety of others and report immediately to management or contact 911.

Review of an email from the AP to the resident's case manager indicated the resident was feeling anxious and uncomfortable at the facility because his ex-girlfriend lived in the neighborhood. The resident stated he could not stay at the facility another night. The AP stated for this reason he placed the resident in a hotel room until a new facility could be found.

During an interview, the Licensed Assisted Living Director (LALD) stated the resident self-administered his medications. LALD stated the resident was actively looking for another place to stay because he was uncomfortable with his ex-girlfriend living close to him. LALD stated the resident stated he was leaving the facility no matter what, therefore staff placed him in a hotel room.

During an interview, a Case Manager (CM) stated they were notified that the resident was placed in a hotel because he was not feeling safe at the facility. The new group home reported to the CM that the resident did not have all of his medications. However, the licensee told the CM all medications were sent with the resident. The CM stated the resident was paranoid that his ex-girlfriend's family members were going to come to the facility and harm him.

During an interview the resident stated he heard the children of his ex-girlfriend at the house threatening to harm him and he was afraid. The resident stated for that reason the AP put him in a hotel for one week until he could be placed in a new facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes.

Family/Responsible Party interviewed: No, resident was independent.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility notified case worker the resident was temporarily placed in a hotel.

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>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2025
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NAME OF PROVIDER OR SUPPLIER GRACE HAND GROUP HOME LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1523 GIRARD AVENUE NORTH MINNEAPOLIS, MN 55411
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL353071421C/#HL353076882M</p> <p>On February 19, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Comprehensive Home Care Assisted Living license. The following correction order is issued.</p> <p>The following correction order is issued #HL353071421C/#HL353076882M, tag identification 1130 and 2360.</p>	0 000	<p>The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
01130 SS=G	<p>144G.55 Subd. 2 Safe location</p> <p>A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing</p>	01130		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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01130	<p>Continued From page 1</p> <p>or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies.</p> <p>This MN Requirement is not met as evidenced by: Based on interviews, and document review, the licensee failed to ensure adequate supervision for one of one resident (R1), in accordance with accepted health care standards, when the licensee did not provide staff to supervise a resident who was placed in a hotel room before placement at a new facility. R1 was left on his own and unsupervised for five days. The action of the licensee placed the resident at high risk for harm.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>R1 admitted to the facility on August 28, 2024, with medical diagnoses to include diabetes, bipolar disorder, major depression disorder recurrent, severe with psychotic symptoms, cannabis and alcohol abuse, and post-traumatic stress disorder.</p>	01130		
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01130	<p>Continued From page 2</p> <p>R1's unsigned service plan dated February 19, 2025, indicated R1 received services for behavior management four times a day, grooming assistance, safety checks four times a day, socialization three times a day, and vital signs once a week.</p> <p>R1's service recap summary dated September through October 2024, indicated R1 received services for behavior management four times a day, grooming assistance two times a day, safety checks four times a day, socialization three times a day, and vital signs once a week.</p> <p>R1's Individual Abuse Prevention Plan dated November 5, 2024, indicated R1 was self-administering his medications, however, was vulnerable in the following areas: needed reminders to take medications, needed help with topical medications, needed reminders for grooming and hygiene, needed daily housekeeping, and laundry service. R1 also had a history of drug and alcohol use, paranoia, and depression, and should be reported to the nurse if evident. The resident's vulnerability assessment indicated the resident required 24-hour staff. Staff were to monitor for behaviors that threatened the resident's safety and safety of others and report immediately to management or contact 911</p> <p>Review of an email from the the Operations Manager to R1's case manager dated November 1, 2024, indicated R1 was feeling anxious and uncomfortable at the facility because his ex-girlfriend lived in the neighborhood. R 1 stated he could not stay at the facility another night. The Operations Manager stated for that reason he placed R1 in a hotel room.</p>	01130		

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01130	<p>Continued From page 3</p> <p>During an interview on February 19, 2025, at 11:09 a.m., the Licensed Assisted Living Director (LALD) stated R1 self-administered his medications. LALD stated R1 was actively looking for another place to stay because he was uncomfortable with his ex-girlfriend living close to him. LALD stated R1 stated he was leaving the facility no matter what, therefore staff placed him in a hotel room.</p> <p>During an interview on March 12, 2025, at 1:24 p.m., a Case Manager (CM) stated they were notified that R1 was placed in a hotel because he was not feeling safe at the facility. The new group home reported to the CM that R1 did not have all of his medications. However, the licensee told the CM all medications were sent with R1. CM stated R1 was paranoid that his ex-girlfriend's family members were going to come to the facility and harm him.</p> <p>During an interview on February 19, 2025, at 2:00 p.m., R1 stated he heard the children of his ex-girlfriend at the house threatening to harm him and he was afraid. R1 stated for that reason the Operations Manager put him in a hotel for one week until he could be placed in a new facility.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: SEVEN (7) days.</p>	01130		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment</p>	02360		

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02360	<p>Continued From page 4</p> <p>covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		