Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368706404M
Compliance #: HL368702039C

Date Concluded: January 22, 2024

Name, Address, and County of Licensee Investigated:
Angel's Health and Home Care Services
5833 Pearson Drive
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela, RN
Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The alleged Perpetrator (AP), unlicensed personnel (ULP), neglected the resident when the AP refused to turn and reposition the resident upon the resident's request, did not use sterile supplies when performing catheterization, and shoved food in the resident's mouth while assisting the resident with eating.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if neglect occurred, as there was no witness to the incident(s) and conflicting accounts of the incident(s) were provided by the resident and the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, employee records, facility policies and procedures, and hospital records.

The resident resided in an assisted living facility. The resident's diagnoses included quadriplegia and neuromuscular dysfunction of the bladder. The resident's service plan included for staff to assist with meals six times per day, monthly licensed nurse supervision with catheter cares, and the use of an air mattress to prevent pressure areas. The resident's assessment indicated the resident required staff assistance with all activities of daily living, utilized a mechanical lift for all transfers, required assistance with daily catheterization, assistance with range of motion exercises, and turning and repositioning every two to three hours and as needed.

Complaint documents indicated the AP refused to reposition the resident upon his request, did not use sterile supplies while performing catheter care, and shoved food in the resident's mouth while assisting the resident with eating. Complaint documents indicated the AP got upset when the resident commented on the AP's behavior and did not respond nicely to the resident's requests.

When facility management became aware of concerns regarding the AP, the AP was removed from the schedule. The resident refused to be cared for by the AP and the facility made attempts to adjust staffing schedules to accommodate the resident's needs and request to not be cared for by the AP.

During the time the AP was removed from the schedule, the resident was transferred to the hospital. Following the resident's hospital admission, the resident did not return to the facility.

Review of facility documentation indicated care was provided in accordance with the resident's service plan. There was no video footage available for review and no witness to the AP's care of the resident.

During an interview, facility administrative staff stated they investigated the concerns related to the AP but were unable to determine if the alleged incidents occurred.

During an interview, facility nursing staff stated the resident directed his own care and would inform staff on how and when to turn and reposition him. The nursing staff stated unopened, sterile, catheterization kits were stored in the resident's room and the resident observed and directed staff on how to perform catheter cares. Nursing staff indicated all caregivers, including the AP, were trained on how to perform tasks required to care for the resident.

During an interview, the AP did not recall any issues with turning and repositioning the resident. The AP stated he used a new catheter kit each time he provided catheter care. The AP stated the resident decided when his catheterization cares should be completed and verbally directed and observed the AP complete the task. The AP denied becoming upset with the resident or shoveling food into the resident's mouth while providing feeding assistance.

During an interview, the resident felt the AP complained when he requested to be turned and repositioned. The resident stated he informed facility administrative staff of his concerns, but

the issue continued. The resident stated when the AP performed catheter care, sterile equipment was used, but the AP would touch unsterile areas with the clean equipment. When the resident re-directed the AP, the AP became argumentative. The resident also felt the AP did not give him enough time to chew his food during mealtime assistance and felt as though the AP was rushing him to eat. The resident stated he refused to be cared for by the AP and transferred to another facility.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, declined to be interviewed.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and provided re-education to the AP following the incident.

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
	36870	A. BUILDING: _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HEALTH & HOME CARE SERVICES	5833 PEARSON DRIVE 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 December 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL368702039C/#HL368706404M. No correction orders are issued.	0 000		