Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393296365M
Compliance #: HL393292115C

Date Concluded: June 29, 2023

Name, Address, and County of Licensee Investigated:
Angels Health and Home Care Services inc.
14297 Zilla Street Northwest
Andover, MN 55304
Anoka County

Facility Type: Unlicensed Facility

Evaluator's Name: Kris Detsch, RN
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 a resident when they failed to provide services to him which resulted in isolation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident said he was free from harm and denied any facility wrongdoing.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted case managers. The investigation included review of the resident's care plan and service agreement. Also, the investigator toured the facility and observed the resident interact with staff.

The resident resided in an unlicensed facility. The resident's diagnoses included diabetes, kidney disease, chronic pain, depression, and anxiety. The resident's service plan included assistance

with bathing, dressing, grooming, and meal assistance. Also, the resident required medication and behavior management.

During an interview, a caregiver said the resident required assistance with meal preparation and housekeeping. The caregiver said she reminds him to take his medications, however he was able to set up and administer his own medications. The caregiver said the resident was independent with all dressing cares and had no limitations with mobility. The caregiver said the resident owned a vehicle and left the facility independently for outings.

During an interview, a manager said the resident was verbally and physically aggressive with staff. The manager said the resident refused care from staff frequently, but staff were always available to assist him. The manager said he was working with other care providers to meet the needs of the resident.

The resident declined an interview but said he was “fine,” and there was no wrongdoing from the facility.

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:
(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: No. Declined a formal interview.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated the resident’s care with other agencies.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39329	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HEALTH & HOME CARE SERVICES INC	14297 ZILLA STREET NORTHWEST ANDOVER, MN 55304

(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 ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: #HL393292115C/#HL393296365M and #HL393296101C On June 27, 2023, 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 was one resident receiving services from the entity. The following correction order is issued for #HL393296101C, tag identification 0100. At the time of the investigation, the entity "Angels Health and Home Care Services Inc." did not hold an Assisted Living Facility license. The entity is required to either immediately cease operating as an assisted living facility or to promptly apply for appropriate licensure. Any other violations which are listed here do not include a time period for correction. In the event the entity is licensed or permitted to operate in the future, it is required to immediately correct those violations.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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. 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:? (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with dementia care license for a building that is on a	0 100		

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0 100	Continued From page 2 campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to obtain licensure while providing services to one resident (R1). The facility provided assistance with activities of daily living, medication services, and behavior management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On September 21, 2022, Minnesota Department of Health (MDH) accepted the facilities plan for licensure, however on November 10, 2022, the facility did not pass inspection. On June 27, 2023, at 9:27 a.m., surveyor arrived at the facility located at 14297 Zilla Street Northwest in Andover, Minnesota, and R1 opened the door. R1 was in his night clothing and said the surveyor woke him up. R1 said he lived at the home and a worker was sleeping downstairs. R1 walked downstairs and surveyor heard R1 shouting at unlicensed personnel (ULP)-C to get up. ULP-C walked up the stairs to the surveyor in her night clothing. During an interview on June 27, 2023, at 9:35 a.m., ULP-C said she worked at the facility and	0 100		

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0 100	Continued From page 3 provided cares to R1. ULP-C said she worked from 8:00 a.m. to 8:00 p.m., Monday through Friday. ULP-C said another staff worked on the weekends. ULP-C said there were times she slept at the facility. ULP-C said she provided meals to R1 and cleaned the facility. ULP-C said she reminded R1 to take his medications, but he could set them up and self- administer. ULP-C said she took R1's vital signs because he had blood pressure problems. ULP-C said one day prior she contacted the nurse because R1's blood pressure was high. ULP-C said the nurse instructed her to send R1 to the hospital, however he refused to go. During an interview on June 27, 2023, at 1:34 p.m., director (D)-A said R1 was at a licensed facility, however R1 was involved in an altercation with another resident, and he moved R1 on November 1, 2022, to the current unlicensed facility. D-A said he was trying to find alternative placement for R1. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		