DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394056684M
Compliance #: HL394051013C

Date Concluded: March 14, 2025

Name, Address, and County of Licensee Investigated:
Independent Group Home
2226 Irving Avenue North
Minneapolis, MN 55411
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 facility staff member, neglected resident #1, resident #2, resident #3, and resident #4, when the AP took the residents' medical records after the AP's employment ended. The facility was unable to provide services to resident #1, resident #2, resident #3, and resident #4 without their medical records.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the AP removed resident #1, resident #2, resident #3, and resident #4's medical records from the facility, due to incomplete and conflicting accounts, it could not be determined if the four residents received services according to their care plan.

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

and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

Resident #1 resided in an assisted living facility. Resident #1’s diagnoses included schizophrenia, depression and bipolar disorder. Resident #1’s service plan included medication assistance. Resident #1’s assessment indicated the resident was independent with activities of daily living and was cognitively intact.

Resident #2 resided in an assisted living facility. Resident #2’s diagnoses included kidney failure and schizophrenia. Resident #2’s service plan included medication assistance and three times a week appointment reminder. Resident #2’s assessment indicated the resident was independent with activities of daily living and was cognitively intact.

Resident #3 resided in an assisted living facility. Resident #3’s diagnoses included attention-deficit hyperactivity disorder. Resident #3’s service plan included medication assistance. Resident #’3’s assessment indicated the resident was independent with activities of daily living and was cognitively intact.

Resident #4 resided in an assisted living facility. Resident #4’s diagnoses included depression and anxiety. Resident #4’s service plan included medication assistance. Resident #4’s assessment indicated assistance with bedmaking, laundry and housekeeping. Resident #4’s assessment indicated the resident was cognitively intact.

Incident documents indicated the AP removed resident #1, resident #2, resident #3, and resident #4’s medical records from the facility after the AP’s employment ended.

The police report indicated one day the medical records of the residents were taken from facility by the previous licensed assisted living director (AP). The facility’s medication administration records indicated resident #1, resident #2, resident #3, and resident #4’s medication administration documentation resumed 16 days following the medical records being removed from the facility. In addition, resident #1’s assessment was the first of the other three residents to be completed 24 days following the medical records being removed.

Review of the four resident medical records indicated the days following the medical records being removed from the facility, the facility lacked documentation that scheduled services, including medication administration were provided to the residents.

During an interview, a nurse stated the resident’s medical records were removed from the facility prior to him starting employment at the facility. The nurse stated he notified the pharmacy, the resident’s physicians, and documentation was gathered to continue cares for the residents.

During an interview, leadership stated the AP's employment was ended and the AP took resident #1, resident #2, resident #3, and resident #4's medical records. Leadership stated after the AP took the medical records, a nurse was hired, new assessments were completed on all four residents, and cares for the residents continued without disruption.

During an interview, the AP stated he did not take the four resident medical records. The AP stated the resident records were at a different office space other than the facility.

During an interview, resident #1 and resident #4 stated they had no concerns with cares at the facility. Both residents stated they had received medications and cares from the facility after the AP took the resident records.

The police report indicated there was not enough evidence to further pursue an investigation and the case was closed.

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: Resident #1 and resident #4 were interviewed. Resident #2 could not be interview due to a hospitalization. Resident #3 was attempted but did not reach.
Family/Responsible Party interviewed: All four residents were responsible for themselves.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
All four resident pharmacy and doctors were notified, information was gathered, and the four residents had an assessment completed. The facility also installed an electronic medical record system.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39405	A. BUILDING: ____ B. WING ____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT GROUP HOME INC	**2226 IRVING AVENUE NORTH MINNEAPOLIS, MN 55411**

(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****** 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: #HL394056684M / #HL394051013C On February 19, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL394056684M / #HL394051013C, tag identification 650 and 720.	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 Facilities. 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 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee (licensed assisted living director (LALD) reviewed. 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, but was not likely to cause 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	0 650		

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0 650	Continued From page 2 situation has occurred only occasionally). The findings include: On February 19, 2025, during an onsite visit at the licensee, a request for the LALD-D employee file was made. During an interview on February 20, 2025, at 8:18 a.m., licensee owner (LO)-C stated when LALD-D employment was terminated, LALD-D stole resident information, employee information, security camera footage, and the licensee's license. On February 20, 2025, at 11:24 a.m. an email from the licensee indicated LALD-D employee file was stolen by LALD-D and that no information was available for LALD-D. The licensee's Record Retention policy dated October 25, 2024, indicated employee records would be retained for seven years after termination. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon	0 720		

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0 720	Continued From page 3 request. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain resident records for four of four residents (R1, R2, R3, and R4). Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. 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, but was not likely to cause serious injury, impairment, or death), and is 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 of the residents). Findings include: A law enforcement report indicated on October 7, 2024, licensee's owner (LO)-C reported that a former employee stole all of the resident medical records. Medication Administration Record (MAR) for R1, R2, R3, and R4, indicated medication administration started October 24, 2024. The MAR lacked evidence of medication administration from October 1, 2024, through October 23, 2024. Service Plans dated November 1, 2024, indicated R1, R2, R3, and R4 received staff assistance with medication administration.	0 720		

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0 720	Continued From page 4 During an interview, on February 20, 2025, at 8:19 a.m., LO-C stated a former employee, licensed assisted living director (LALD)-D stole the medical records of the four residents that resided at the licensee. The licensee's Record Retention policy dated October 25, 2024, indicated resident records would be retained for seven years after discharge. Time Period for Correction: Seven (7) days.	0 720		