Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL29190003M
Compliance #: HL29190004C

Date Concluded: March 19, 2020

Name, Address, and County of Licensee Investigated:
1-0 Granny's Helpful Hands
4301 Welcome Avenue North
Crystal, MN 55422
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Carrie Euerle RN, MPH
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An unannounced visit was conducted to investigate 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(s):
It is alleged facility staff failed to supervise the client when a staff member went with the client to a local bar. The client broke sobriety and also paid for the staff member's drinks using her personal funds.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide the level of supervision which was reasonable and necessary, when the client's service agreement indicated the client was to be supervised at all times in the community and had a plan in place to assist the client in maintaining sobriety, but the client went to a nearby bar without any staff interventions.

The investigation included interviews with facility staff members, including administrative staff and unlicensed staff. No observations were made as the client no longer resided at the facility and no clients currently resided in the facility at the time of the investigation.

The client was admitted to the facility with diagnoses which included borderline personality disorder, anxiety, and depression. The client also had a history of alcohol use and self-injurious behavior. The client had recently discharged from a treatment center and was under commitment of the facility. The client had a relapse and prevention plan which indicated that if the client was heading to an establishment that sold liquor, staff were to call 911. The client's person centered support plan indicated maintaining sobriety was important to the client. The client was directly supervised by facility staff with one-to-one supervision due to the client's history of self-injurious behavior. The client's service plan indicated the client was not allowed to be alone in the community due to mental health symptoms and cognitive abilities, and was to be supervised by staff while in the community.

The client reported to facility staff that she and a staff member had left the facility to go to the bar. The client reported the staff member took her in the staff member's personal car to the bar and the client paid for both her and the staff member's drinks. The client provided a date the incident occurred and stated that the bar near the facility had a dart tournament that same evening. This incident was not reported by the client until several months after the incident occurred. The client indicated she only reported the incident because she broke her sobriety and felt she needed to report the incident. At the time of the report made by the client, the client named a specific staff member who was working over the time period indicated by the client.

Upon receiving the report of the incident by the client, facility staff investigated the incident. At the time, the staff member no longer worked at the facility and when questioned, denied taking the client to the bar. The facility reviewed staffing schedules and interviewed the other staff member who worked that same evening. The other staff member could not recall any smell of alcohol on the client or staff member and was unaware of any incident that may have occurred. The facility identified that the described incident reported by the client may have occurred, as they called the bar and it was confirmed there was a dart tournament that same day, but were unable to further corroborate whether the incident occurred.

The client was interviewed and stated she did not recall the name of the staff member but did recall the incident. The client indicated she and the staff member were the only two people at the facility at the time of the incident. The client indicated she said to the staff member "I'm bored, let's go to the bar" so her and the staff member left to go to the bar near the facility. The client indicated she paid for the drinks that they both had and stated they had about 6 or 7 drinks and that there was a dart tournament that weekend. The client was able to recall the specific date that the incident occurred. The client confirmed she did not report the incident until a few months later due to being upset for breaking her sobriety but felt the need to report on herself and the staff member.

At the time of the interview, the client could not recall if she paid for the drinks in cash or via credit card but later provided her credit card statement which had withdrawals and charges

made at the bar named by the client around the same date in which the client indicated the incident occurred.

Review of the credit card statement indicated that a withdrawal of $43.00 was made from an ATM at the bar on the date the client had said that the incident occurred. In addition, two days later, a charge of $35.50 was deducted from the client's account from the same establishment.

The AP was interviewed and denied taking the client to the bar that evening, or ever drinking alcohol with the client.

The other staff member working at the time of the incident did not respond to requests for interview.

In conclusion, neglect was substantiated. Although there is not a preponderance of evidence whether the client left the facility alone, or the identity of the staff member who may have been with the client at the bar, there is a preponderance of evidence that the facility failed to provide the supervision and interventions the client was assessed as requiring. There is corroboration that the client went out into the community and into an establishment which sold alcoholic beverages, and likely purchased alcoholic beverages, and no staff member implemented the planned interventions for that situation or documented the incident.

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: Yes
Family/Responsible Party interviewed: No, the client is currently responsible for her own care
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility was unaware of the allegation until months after the incident occurred. At that time, the AP was no longer employed by the facility. In addition, the client was later hospitalized and did not return to the facility.

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 http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm, 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:
Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Crystal City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29190	A. BUILDING: _____ B. WING _____	C 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1-0 GRANNY'S HELPFUL HANDS LLC	705 EAST LAKE STREET MINNEAPOLIS, MN 55407

(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****** 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 a survey. 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 January 9, 2020 the Minnesota Department of Health initiated an investigation of complaint #HL29190003M & HL29190004C. At the time of the survey, there were 11 clients receiving services under the comprehensive license. The following correction orders are issued for, tag identification 0325 and 0865.	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).	

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0 325	Continued From page 1	0 325		
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to 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 staff failed to supervise C1 according to C1's service and relapse plan. Findings include: On March 16, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was 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) required. Please refer to the maltreatment public report for details.	
0 865 SS=D	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service	0 865		

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0 865	Continued From page 2 plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to implement the client's service plan for one of one clients (C1), when the supervision indicated on C1's service plan and relapse prevention plan was not implemented by	0 865		

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0 865	Continued From page 3 facility staff. C1's service plan indicated C1 required supervision in the community due to mental health needs, and C1's plan included that staff were to call 911 if C1 went to a place that sold alcoholic beverages, however C1 went to a bar and no staff interventions were implemented. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1 was admitted to the facility on 1/29/2019 with diagnoses which included borderline personality disorder, anxiety and depression. The client also had a history of alcohol use and self-injurious behavior. C1's signed service agreement dated 1/29/2019 indicated the client was not allowed to be alone in the community due to mental health symptoms and cognitive abilities. In addition, the service plan indicated the client was to be supervised by staff while in the community. C1 also had a signed Relapse and Crisis Prevention Plan dated 2/22/2019 which directed staff to call 911 if the client was heading to an establishment that sold liquor. A facility incident report dated 8/19/2019 indicated that, on 4/6/2019, C1 went to the bar	0 865		

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0 865	Continued From page 4 with a staff member (unlicensed personnel) ULP-C and paid for herself and the staff member's drinks. A facility internal investigation dated 8/19/2019 indicated that facility administration investigated the 4/6/2019 incident involving C1 and ULP-C. The internal investigation indicated that another staff member (unlicensed personnel) ULP-D working on 4/6/2019 did not witness or have any indication that C1 had left with the ULP-C and was not able to smell alcohol on C1 or ULP-C. The internal investigation indicated it was unable to determine if the incident occurred and ULP-C denied taking C1 to the bar, and no longer worked at the facility at the time the incident was reported. An interview with C1 on 2/13/2020 at 2:55 p.m. indicated C1 recalled the incident. C1 stated that ULP-C asked C1 if she wanted to go to the bar and C1 said yes. C1 stated that they went to a bar near the facility and C1 paid for her and ULP-C's drinks. C1 could not recall the name of the staff member but stated she had told the facility administration the staff member's name at some point. C1 stated the date the incident occured was 4/6/2019 and wanted to provide her bank statements that displayed she withdrew money and used her credit card on that date at the bar. A review of C1's bank statement indicated on 4/6/2019 an ATM withdraw was made from C1's bank account, for an amount of $43.00, at the bar and on 4/8/2019 a transaction was processed for the amount of $35.50 from the same bar. Interview with the housing director on 2/24/2019	0 865		

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0 865	Continued From page 5 at 3:01 p.m. indicated that the facility completed an internal investiation surrounding the incident but were unaware of the alleged incident until several months later. The housing director indicated that ULP-C no longer worked at the facility at the time they learned of the allegation, however was still interviewed during the internal investigation and denied taking C1 to the bar. The housing director indicated they had not been provided any bank statements to display that this incident occurred and so had not been able to corraborate that the incident occurred. The housing director indicated C1 no longer resided at the facility, but stated staff should have been following C1's service plan at all times, and C1 was required to be supervised at all times in the home and when out in the community. A policy on service plan implementation was requested, however not provided by the facility. Time Period for Correction: Twenty one (21) days	0 865		