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 #: HL350191582M
Compliance #: HL350193075C

Date Concluded: June 6, 2023

Name, Address, and County of Licensee Investigated:
MN Best Home Care
6264 Sunrise Terrace
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Inconclusive
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 staff did not check on the resident during the night. The next day the resident was found incoherent and required emergency medical assistance. Also, the alleged perpetrator (AP), facility staff, physically abused the resident when the AP pushed the resident and used inappropriate language when interacting with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident indicated staff slept during the night of the resident's unresponsive episode, the recorded video did not show staff sleeping. In addition, it could not be determined if staff failing to check on the resident could have prevented the resident's unresponsive episode the following morning. The hospital summary indicated the cause of the resident's unresponsiveness was undetermined.

The Minnesota Department of Health determined physical abuse was not substantiated. Although the incident occurred and the AP did not treat the resident with courtesy and respect during their interaction, it did not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the ombudsman and the residents case manager. The investigation included review of resident and employee records, facility policies and procedures, and recorded video clips from a camara placed in the resident's room. Also, the investigator observed the daily routine and care of the resident.

The resident resided in an assisted living. The resident's diagnoses included quadriplegia, chronic suprapubic catheter (tube place through the abdomen to kidney to drain urine), attention-deficit, hyperactivity disorder, depression, anxiety, seizure disorder, and insomnia. The resident's service plan included assistance with medication management, reassurance checks, toileting and bathing assistance, transfer and repositioning assistance, and assistance with all activities of daily living. The resident's assessment indicated the resident was vulnerable in all functional categories.

One morning when the dayshift staff arrived, they checked on the resident and he was babbling and incoherent. They called the nurse who instructed them to call 911. The staff member reported to 911 that the resident was unresponsive and was instructed to begin cardio-pulmonary resuscitation (CPR). When the emergency medical services (EMS) arrived the staff member was instructed to stop CPR as the resident was conscious.

Review of a recorded video from the resident's phone regarding staff sleeping, in the recording neither the resident nor staff can be seen. On the video snoring can be heard and the resident called a staff members name and eventually the staff member responded to the resident.

Review of recorded video clips from a camera in the resident's room, from the nightshift to the dayshift, showed the resident's room. The resident and the door entering the room were outside of the camara frame, therefore it was not possible to see if staff entered the room or viewed the condition of the resident. The resident could be heard on the video moaning and babbling, and at one point called out for help.

During an interview, the nurse stated a staff member called him in the morning and stated the resident was incoherent and not responding appropriately. The nurse instructed staff to call 911. The nurse stated two nightshift unlicensed personnel (ULP)'s stated there was nothing unusual that happened with the resident during the night. They did hear the resident making sounds but that was normal for him. The staff members stated they checked on the resident during the night by going to his door but not going in the room.

During an interview the ULP stated she followed the night routine with the resident and the last thing she did for him was brush his beard. The ULP stated the resident came to his doorway late in the evening and she asked if he needed anything, and he said no. The ULP stated the last time she saw the resident was after midnight and he was sleeping in his chair with the door

slightly open. The ULP stated the resident did not call for assistance during the night. The ULP stated when she emptied the resident's catheter bag in the morning he was sleeping.

During an interview, the second ULP stated the resident slept in his chair that night and fell asleep after midnight with his door open. The ULP stated she checked on the resident every two hours by walking past his door. The ULP stated the resident would request staff assistance by using his phone to call for assistance or just called out to staff if he needed anything, however, the resident did not call for assistance that night.

During an interview, the resident stated he did not remember anything about that night or the next morning. The resident stated prior to this incident staff members did not provide care the way that he wanted it done and he would often refuse.

During an interview, a family member (FM) stated she received a call from the facility that the resident was unresponsive and needed to be transported to the hospital. The FM was later informed by the hospital that it was unclear what caused the episode. The FM stated she reviewed recorded video from the camara in the resident's room and did not see staff enter the room at all during the night to check on the resident who sounded as if he was in distress.

Review of recorded video clips in the resident's room showed the AP and another ULP preparing to assist the resident to transfer the resident from the bed to the wheelchair. The resident was turned on his left side and asked the AP for a paper towel and the AP stated, "you can wait." The resident spit several times toward the legs of the AP and stated, "good it is all over your pants." When the AP bent over to check his pants the resident spit again. The AP stood up and quickly pushed the resident away from him by the resident's shoulder. The AP and the resident exchanged words back and forth. The AP pulled a pillow from under the resident's head without supporting his head and the resident's head plopped down on the bed.

During an interview, the AP stated the resident provoked him to raise his voice so that he could record him. The AP denied arguing with the resident. The AP stated the resident spit on him, and he responded by continuing to provide services and reported the incident to the nurse.

While there were multiple complaints regarding staff not providing services according to the resident's care plan, review of the resident's records indicated staff provided care plan needs as resident allowed.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive and physical abuse was not substantiated.

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.

“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 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility retrained staff on providing resident care and professional behavior expectations.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35019	A. BUILDING: _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN BEST HOMECARE LLC	6264 SUNRISE TERRACE BROOKLYN PARK, MN 55428

(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 LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL350193075C/#HL350191582M On February 7, 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 were four residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL350193075C/#HL350191582M, tag identification 2350.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with	02350		

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02350	Continued From page 1 courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interviews and recorded video review, the facility failed to ensure residents were treated with courtesy and respect for one of two (R1) residents 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) 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). The findings include: R1's medical record indicated R1 was admitted to the facility on November 29, 2019, with diagnoses that included quadriplegia, chronic suprapubic catheter (tube through the abdomen to the kidney to drain urine), attention-deficit, hyperactivity disorder, depression, anxiety, seizure disorder, insomnia, pressure ulcer wound. R1's care plan indicated R1 received services for medication management, reassurance checks, toileting and bathing assistance, transfer and repositioning assistance, and assistance with all activities of daily living. R1's vulnerability assessment undated, indicated R1 was vulnerable in the areas of anxiety and depression, inability to ambulate, range of motion, endurance, strength, and chronic conditions. The assessment also indicated R1 posed a potential risk to others because of his spitting and verbal	02350		

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02350	Continued From page 2 abuse towards others. Review of recorded video clips dated January 12, 2023, from 6:27 a.m. to 6:30 a.m., indicated ULP-D and ULP-E were preparing to transfer R1 from the bed to the wheelchair. R1 was turned on his side and he asked for a paper towel from ULP-D who stated "you can wait." R1 spit several times toward the legs of ULP-D and then stated, "good it is all over your pants." When ULP-D bent over to check his pants R1 spit again. ULP-D stood up and quickly pushed R1 away from him by his shoulder. ULP-D and R1 exchange words back and forth. ULP-D pulled a pillow from under R1's head without supporting his head and R1's head plopped down on the bed. R1 yells at ULP-D "dude you better stop!" R1 and ULP-D exchanged words. During an interview on February 27, 2023, at 3:03 p.m., ULP-D stated R1 provoked him to raise his voice so that he can record him. ULP-D stated he did not argue with R1. ULP-D stated R1 spit on him, and his response to continue providing services to R1 and ULP-D reported the incident to the nurse. The licensee's policy titled Home Care Bill of Rights undated, indicated residents have the right to be treated with courtesy and respect. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02350		