Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356394843M
Compliance #: HL356396349C

Date Concluded: October 31, 2024

Name, Address, and County of Licensee Investigated:
Angel's Health and Home Care Services
4213 63rd Ave N
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
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 financially exploited the resident, (Resident #1), when, the resident's pain medication was delivered to the facility and another resident, (Resident #2), signed for the medication by falsely using a staff member's name. Resident #1's pain medication, which was a controlled substance, (narcotic,) was missing from the delivery.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. Although Resident #1's narcotic pain medication was missing, Resident #1 did not miss a scheduled dose of the medication and a new non-opioid pain medication was ordered by the physician. Facility staff reported the incident to law enforcement and initiated an internal investigation into the incident. Following the incident, a new process was implemented to ensure better coordination with the pharmacy for delivery of medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted pharmacy personnel and law enforcement. The investigation included review of the resident record(s), death record, pharmacy records, a facility incident report, personnel files, staff schedules, a law enforcement report, and related facility policies and procedures. Also, the investigator observed staff interactions, medication administration, treatment administration, and the facility environment which included posted pharmacy delivery instructions on the front door.

Resident #1:

The resident resided in an assisted living facility. The resident's diagnoses included depression and chronic pain syndrome. The resident's service plan indicated the resident received daily assistance with activities of daily living, medication management, and safety checks three times per day. The resident's assessment indicated the resident's cognition was intact but had impaired judgement and a history of substance abuse. Staff monitored the resident daily for pain, behaviors, and drug use.

Resident #2:

The resident resided in an assisted living facility. The resident's diagnoses included staff schizophrenia and bipolar disorder. The resident's service plan indicated the resident received daily services for staff assistance with dressing, medication management, and behavior monitoring. The resident's assessment indicated the resident was alert but occasionally disoriented and forgetful. Staff monitored the resident daily for behaviors and drug use.

A pharmacy delivery driver delivered medication to the facility. Resident #2 was sitting outside at the time of delivery. The delivery driver did not enter the facility to deliver the medications or ask for facility staff upon arrival to the facility. Resident #2 signed a staff member's name and accepted the pharmacy delivery of medications. The facility staff working at the time was not aware that a pharmacy delivery was made until Resident #2 brought the medications into the facility and set them on the table. Staff attempted to communicate with the pharmacy driver, but the pharmacy driver left before speaking with staff. Staff did not review or take inventory of the delivered pharmacy medications. Staff text the facility nurse to report the incident and place the unopened bags of medications in the locked medication cabinet.

The next day, the medications were reviewed, and it was discovered that Resident #1's narcotic was missing from the delivery. The facility contacted the pharmacy who indicated the narcotic was delivered with the other medications last evening. Law enforcement was contacted, and an internal investigation was initiated upon learning of the missing narcotic medication.

During the internal investigation, Resident #2 admitted to intercepting the narcotic medication at the time of the pharmacy delivery. Resident #1's physician was contacted, and the medication was discontinued. Resident #1 did not miss a scheduled dose of narcotic medication a result of the incident. Law enforcement closed the case, and no charges were filed.

The internal investigation summary indicated there were breakdowns in the process of pharmacy delivery of medication and intake of medications by the facility. Following the incident, a new process for pharmacy delivery was implemented and additional auditing of medications was implemented.

During an interview, a facility staff member recalled Resident #2 came into the facility with two, stapled bags of medication that she immediately locked in the medication cabinet. The facility staff member did not know medication was being delivered that day and did not see the pharmacy driver deliver the medication. After the medications were locked in the medication cabinet, she notified the licensed nurse of the incident.

During an interview, the facility licensed nurse stated that during a facility investigation interview, Resident #2 admitted to intercepting the narcotic medication but could not inform them of where the medication went. Resident #1 was informed of the incident and the narcotic medication was discontinued and a new order for non-opioid pain medication was provided by the physician. The nurse stated they discussed a new process with the pharmacy to ensure better coordination of medication delivery.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority, a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed (resident #1): No. Resident did not respond to requests for interview.

Family/Responsible Party interviewed (Resident #1): N/A. Resident responsible for self.

Vulnerable Adult interviewed (Resident #2): No. The resident did not respond to requests for interview.

Family/Responsible Party interviewed (Resident #2): N/A. Resident responsible for self.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility contacted law enforcement, completed an internal investigation, and a new process was implemented for delivery of pharmacy medication.

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
	35639	A. BUILDING: _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HEALTH & HOME CARE SERVICES INC	4213 63RD AVENUE NORTH 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 INITIAL COMMENTS: #HL356396349C/ #HL356394843M On September 24, 2024 through October 8, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE