Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL365702642M
Compliance #: HL365704422C

Date Concluded: September 7, 2023

Name, Address, and County of Licensee Investigated:
American Best Home Care Inc
7124 West River Road
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 the resident eloped from the facility, consumed alcohol, and became intoxicated. Subsequently, the resident was hit by a car and died from injuries sustained from the accident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the incident occurred, physician orders indicated the resident was able to independently leave the facility without supervision. The resident had a history of elopements and self-harm attempts involving vehicles and the facility worked with the resident's physician and care team to develop harm reduction interventions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and the resident's case manager. The investigation included review of the resident's medical record,

police reports, hospital records, personnel files, and facility policies and procedures. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included paranoid schizophrenia, antisocial personality disorder, and alcohol use disorder. The resident's care plan included assistance with medication management, housekeeping, and laundry. The resident's assessment indicated the resident was moderately impaired, required supervision, and had a history of elopements.

The resident's medical record indicated the resident had a long history of struggling with sobriety, wandering, and homelessness. The medical record indicated the resident had not lived in a supportive environment prior to his admission to the facility and had a pattern of quitting or walking away from restorative programs aimed at maintaining sobriety. The resident had a history of threats of harm-to-self and others. Medical records indicated the resident had a history of throwing himself on the road for vehicles to run him over and interventions to prevent and redirect this behavior were implemented to support the resident's safety.

The resident's physician's orders identified the resident was able to leave the facility at any time without family or staff supervision.

The resident's progress notes indicated the resident often left the facility, despite staff's attempts at redirection. The facility nurse discussed with the resident the risks of leaving the facility, however, the resident was not receptive to this education. Progress notes indicated the resident left the facility to panhandle (stop people on the street and ask for food or money) and used the money to buy alcohol and become intoxicated. When intoxicated, the resident would walk to or be taken to the hospital. The hospital would then contact facility staff and have the resident transported back to the facility.

Progress notes indicated the resident left the facility one afternoon to panhandle.

Hospital records from that same day identified the resident was hit by a car going 40 miles per hour. The resident sustained significant injuries and was pronounced dead at the hospital. The facility was informed of the accident by hospital staff.

During an interview, a staff member stated the resident had a history of walking out in front of cars. The resident told the staff member he had been hit by a vehicle 10 times. The staff member stated the resident had approved time alone in the community from his provider, however, interventions were in place for the resident when he wanted to leave facility. Interventions included redirection, contacting 911, and contacting the case manager.

During an interview, the facility nurse stated the resident had been knocked down by a vehicle prior to moving into the facility. The nurse stated the resident often left the facility to panhandle for money to buy alcohol. The nurse stated interventions to prevent the resident

from leaving and getting intoxicated were developed but the resident also was approved to be unsupervised and independent in the community.

During an interview, facility management stated the resident was assessed and safe to be independent in the community. Facility management indicated the resident was not open to redirection and they kept the resident's physician and care team updated on the resident's behavior.

During an interview, the resident's case manager stated the resident had declined multiple opportunities for alcohol abuse treatment and had been involved in several previous accidents involving vehicles. The case manager was aware of the resident's behavior and the resident independently leaving the facility to panhandle.

During an interview, the physician stated the resident's care team had ongoing conversations about the resident's behavior and safety and the goal was harm reduction. The physician stated the facility provided the resident with exceptional care and the resident was at his best when he lived at the facility because they provided good structure.

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 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: No, deceased.
Family/Responsible Party interviewed: No, contact information not available
Alleged Perpetrator interviewed: NA

Action taken by facility:
The facility attempted to provide education and interventions for the resident as well as a structured living arrangement.

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
	36570	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN BEST HOME CARE INC	7124 WEST RIVER ROAD BROOKLYN CENTER, MN 55430

(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 On August 14, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL365704422C/#HL365702642M. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	