Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL367243542M
Compliance #: HL367243842C

Date Concluded: September 23, 2024
Date Revised: January 17, 2025

Name, Address, and County of Licensee Investigated:
Helpful Hands Home Care
6712 Drew Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator
Revised By: Matt Heffron, JD, NREMT
Operations Manager

Finding: Substantiated, facility responsibility

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 the resident when staff failed to supervise and implement safety interventions for a resident with a known drug abuse history. The resident overdosed on drugs and was treated in the hospital.

In addition, the facility neglected the resident when staff failed to supervise the resident when she began to prostitute herself out of the facility, sometimes meeting with up to 14 people in a day over the period of several months. The resident also was subjected to verbal sexual harassment from facility staff and was given hush money in cash and electronic payments from facility management to not complain or report concerns about conditions at the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was ~~and the alleged perpetrators (AP)s were~~ responsible for the maltreatment. The alleged perpetrator (AP) #1, the facility owner and licensed assisted living director (LALD) and AP #2, another facility owner, were aware of the resident's drug abuse history upon admission to the facility and were responsible for the oversight and management of the facility. All facility management staff failed to ensure facility policies and procedures were followed by licensed and unlicensed staff. Facility staff failed to assess and develop an individualized abuse prevention plan (IAPP) that included interventions to ensure the resident's safety, reduce risk of self-harm, and manage the resident's behaviors related to drug use. The resident was noted to have a history of substance abuse and was observed to be under the influence of drugs on multiple occasions while residing at the facility. The resident overdosed and was hospitalized.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, the case manager, and support professionals. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, a law enforcement report, and related facility policies and procedures. Also, the investigator observed the resident's room at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included depression, opioid use disorder, substance abuse, anxiety, bipolar disorder, and post-traumatic stress disorder (PTSD). The resident's service plan included safety checks three times per day, medication administration, behavior management related to agitation, anxiety, property destruction, repetitive behavior, self-injurious behaviors, sexual inappropriateness, substance abuse, and verbal aggression three times per day, and monitoring of mental health needs and wandering three times per day. The resident's assessment indicated the resident had a history of visiting the gas station in search of alcohol or drugs. The resident also had a history of drug use and staff were to monitor for any signs and symptoms of drug overdose. Interventions included observing for changes in behavior/cognitive status, reporting any changes to the nurse, use a warm and friendly approach, and reassure the resident that she is safe and secure. The assessment indicated "NO drugs or alcohol allow on premises. ABSOLUTELY NOT!" Staff were to call 911 "if behavior is at crisis level."

Facility documentation indicated there were at least seven prior incidents of police being called due to the resident being under the influence of drugs. Documentation included at least seven incidents where the resident was noted to be high or under the influence of drugs in the two months prior to the overdose.

A facility report indicated the resident overdosed on drugs one evening after she returned from the gas station. The report indicated the resident's boyfriend called 911 after she became unresponsive. The report indicated that the resident went to the gas station alone around 5pm and the resident's boyfriend was in her room upon her return to the facility. Around 15 minutes

later, the resident was unconscious, and her boyfriend called 911. When police and paramedics arrived, they initiated CPR (cardiopulmonary resuscitation) and inquired about the resident's use of street drugs.

The police report indicated 911 was called and officers arrived four minutes later. Narcan was administered and the resident was taken to the hospital.

Hospital records indicated the resident reported she had "smoked some fentanyl and then does not remember what happened. Paramedics reported that they found the patient unresponsive...The patient does admit to using meth regularly and using it today." The resident was evaluated in the emergency room and discharged back to the facility.

During investigative interviews with unlicensed personnel (ULP), they described the resident as difficult, and that she had an attitude, and used drugs almost every day.

During an interview, a facility nurse was asked if he felt the facility was appropriate placement for the resident and if the facility was able to manage her needs before she was accepted as a resident. The facility nurse stated that he did not complete the preadmission assessment for the resident, and it was completed by the owners of the facility, who were not nurses. The nurse was told by the owners that they had accepted a new resident and needed him to do the admission assessment on the resident. The nurse stated he knew the resident had a history of substance abuse and was "also very disruptive and uncooperative." The nurse stated if the resident was observed to be under the influence of drugs, staff were to check her vital signs and increase the number of safety checks to maybe an hour or every 30 minutes instead of the usual every two hours. The nurse confirmed the facility did not document the increase in services for when the resident was under the influence of drugs. The nurse stated staff knew if the resident went to the gas station, it was likely she went out to do drugs. On the day she overdosed, staff should have noticed her coming back to the facility and assessed to see if she was under the influence. The nurse confirmed an investigation of the overdose was not completed but he asked the resident why she was using drugs and asked the case manager to take the resident to treatment. The nurse was asked if the facility was appropriately staffed and trained to care for residents who were active drug users. The nurse stated, "We are not good for managing people with drug use. I will not accept those kinds of patients to come to the facility again."

During an interview, the licensed assisted living director (LALD)/AP #1 stated the resident used drugs about once a week or every other week and when she was using drugs, "First, we'd have to talk to her and if she doesn't do any self-harm, we'd let her stay in her room and I used to call the case manager and the doctor, sometimes I'd also call her boyfriend...then every 15 minutes we'd check her room until she's ok." The LALD was asked if he felt the interventions in place were sufficient, given the resident continued to use drugs while living at the facility. The LALD stated, "She never used at our place, she'd go out…once she leaves, she can do whatever she wants." The LALD stated he struggled with the resident and that he had tried everything and

spoke to the case managers but was told that the resident had rights and there was nothing they could do about the resident's drug use.

During an interview, AP #2 stated he was aware the resident had a history of drug abuse and a history of multiple overdoses upon admission to the facility but wanted to give her a second chance. AP #2 stated the resident was frequently under the influence of drugs while at the facility and would say she was going to the library and would come back "all messed up, shaking all over and getting mad at everything. We told staff to give her space, just write down in a progress note if anything else happens or if it gets worse to call the nurse first and ask what they can do about it, if the nurse says call the police, then we call the police." AP #2 stated staff were directed to check on the resident every 15 minutes while she was high but confirmed this was not documented anywhere. AP #2 stated that the resident told him she had overdosed a couple of times, so staff were to check on her all the time. AP #2 stated on the day the resident overdosed, her boyfriend was there, and AP #2 talked to them through the camera and the boyfriend said she overdosed.

During an interview, the resident's case manager stated the facility frequently called to complain about the resident due to her behavior or if they felt she was using too many resources from the facility. The case manager stated the facility was not supporting the resident in her areas of need and could never get on board with understanding how to support her without being punitive. The case manager stated the facility wasn't following a plan for the resident so she couldn't make any forward progress. The case manager stated the facility's treatment of the resident appeared to make things worse for the resident's behaviors and drug use. The case manager stated that she tried to have a conversation with staff to work towards the resident's independence and they kept inflecting more structure and limiting her abilities. The case manager stated the resident often isolated in her room and brought food to her room, so she didn't have to leave. The resident reported that night staff were verbally abusing her, and she was hiding and didn't want to come out at night because she didn't want to "make waves". The case manager stated that at one point the resident was isolating so hard that she was concerned it was a tipping point for when the resident started using drugs again. The case manager stated she voiced her frustration to facility management over how frequently staff called 911 for issues that they should have been able to handle. The case manager felt staff were sabotaging the resident's ability to be there and called 911 wanting her removed, but responders would show up and there wasn't an issue. The case manager stated she wasn't immediately updated about the resident's overdose but when she found out, she mailed her Narcan (drug used to treat opioid overdose) because she couldn't rely on the staff to protect the resident. The case manager stated that the resident's house mate died [of an overdose] and the resident was the one who responded to her, and the resident was traumatized by the incident.

During an interview, an outside agency support specialist who worked with the resident stated she had multiple concerns with the facility and felt the facility didn't understand resident rights, assisted living regulations and overutilized calls to 911. The support specialist stated she

reviewed the resident's IAPP and did not feel it was appropriate. The support specialist stated the facility's approach to modifying some of the resident's behaviors was less than what she would have liked to see, and it didn't seem like staff were fully trained on the mental health aspect of what the resident was going through.

During an interview, the resident's mom stated, she had "never received so many phone calls from her [the resident] crying about what was going on there." The resident's mom stated the facility did not update her about the overdose and she only found out after the resident called her. The resident's mom stated she tried to reach out to [management] and "never ever got a phone call back, ever." The resident's mom stated she told the resident she needed to move out of the facility and find a safer place to live.

During an interview, the resident stated she accidently overdosed after smoking some fentanyl and could only recall that she laid down and woke up in an ambulance. The resident stated the facility knew about her drug use but didn't really do anything. The resident stated, "they know what we're doing in the house, they're not stupid, so they know, they're aware, they both are [the LALD and owner] but they just turn their backs." The resident stated she engaged in prostitution for almost three months at the facility and confirmed that up to 15 people would come to the facility each day. The resident stated the facility was aware and the LALD had asked her to not have them sign in anymore and to make sure they didn't stay for a long period of time.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Brooklyn Center City Attorney
Brooklyn Center Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36724	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPFUL HANDS HOME CARE LLC	6712 DREW 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 ******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: #HL367243542M/#HL367243842C On July 30, 2024, 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 was one resident receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL367243542M/#HL367243842C, tag identification 0250, 0630, 2290, 2360, and 2400.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to fully cooperate with an inspection, survey, or investigation by the department. This had the potential to affect all residents, staff, and visitors. 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). The findings include: On July 30, 2024, at 10:36 a.m., the investigator initiated a complaint investigation and emailed licensed assisted living director (LALD)-A a list of records that needed to be reviewed. LALD-A stated he would have to call the clinical nurse	0 250		

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0 250	Continued From page 3 supervisor (CNS)-B as he wasn't able to access some of the records. On July 30, 2024, at 11:45 a.m., the investigator told LALD-A the records would need to be received no later than 4:00 p.m. and LALD-A voiced understanding. On July 30, 2024, at 12:01 p.m., the investigator emailed LALD-A a list of records still needed and requested they be sent by 4:00 p.m. that day. On July 31, 2024, at 8:56 a.m., the investigator emailed LALD-A "I am just following up on the status of the records request. As discussed yesterday in person and via email, the below documentation was to be submitted no later than July 30, 2024, at 4:00 p.m., I did not hear from you that an extension was needed or that there were issues complying with the request. The only documents received were three assessments. The investigation process requires the department look at how your agency operates. To do so we need to see specific records and policies. Below is a list of some of the items we need from you. I am requesting additional information as part of my ongoing investigation pursuant to Minnesota Statute 144A.53 Subd. 1, paragraph 4 and Minnesota Statute 626.557 Subdivision 12b, paragraph g. Please send the requested documentation no later than July 31, 2024, by noon. Failure to send the requested information will result in a correction order for failing to comply with the investigation process. Please let me know if you have any questions." Partial records were provided on July 31, 2024, at 3:28 p.m. On August 1, 2024, at 11:06 a.m. the investigator emailed LALD-A regarding the remaining	0 250		

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0 250	Continued From page 4 documents that had not been submitted, writing "This request was made on July 30, 2024, and again on July 31, 2024. It is imperative that you fully cooperate and provide all requested information in a timely manner. This is the third request for information that was due by Monday, July 30th at 4:00 p.m. Please send no later than 1:00 p.m. today." LALD-A emailed the documents on August 1, 2024, at 2:21 p.m. On August 1, 2024, at 11:55 a.m., the investigator spoke with LALD-A and requested information related to an incident involving an employee and R1 and requested it be sent as soon as possible. On August 1, 2024, at 2:27 p.m., the investigator emailed LALD-A to request information related to an incident involving an employee and R1. On August 5, 2024, at 10:47 a.m., the investigator emailed LALD-A again requesting the information related to an incident involving an employee and R1 be sent no later than noon on August 5, 2024. At 12:13 p.m., LALD-A emailed asking what employee the investigator was referring to. The investigator replied and again requested the incident report and the employee's name. LALD-A replied at 2:03 p.m. with only the employee's phone number. The investigator replied at 2:57 p.m. asking again for the incident report and internal investigation, as well as some additional records for R1. On August 5, 2024, at 4:10 p.m., LALD-A emailed the investigator, "There's a open case so contact our attorney [attorney's name]" The investigator replied, "So to clarify, you will not be providing the incident report or internal investigation related to [ULP-J] alleged actions towards [R1]?" LALD-A wrote back, "I will email your request gime a time	0 250		

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0 250	Continued From page 5 I am not into the office please." The investigator wrote back, "Ok. If you are able to send the following as soon as possible, that would be great. I need it no later than tomorrow as I really want to move this case forward and wrap things up. To recap, I am looking for: Incident report related to the approximately February incident where the ULP refused to let the resident use the phone and allegedly pushed her, if you have camera footage please send that. If completed, an internal investigation (that could include interviews with the ULP, other staff, other residents, the resident in question etc.). MARs for January, February, March. If it is identified [ULP-J] is an alleged perpetrator of substantiated abuse, I would need an employment application which needs to include his full name, DOB, phone number, address, social security number. I did try calling the number provided today, it is out of service and no longer active. If you have questions or anything is unclear, please reach out." No response was received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630		

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0 630	Continued From page 6 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess and develop an individualized abuse prevention plan and implement interventions for one of one resident (R1) to ensure safety, reduce risk of self-harm, and manage R1's behaviors related to drug use. The resident was noted to have a history of substance abuse and was observed to be under the influence of drugs on multiple occasions. The resident later suffered a drug overdose and was hospitalized. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 situation has occurred only occasionally). The findings include: R1's diagnoses included depression, opioid use disorder, substance abuse, anxiety, bipolar 1 disorder, and post-traumatic stress disorder (PTSD). R1's service plan dated January 1, 2024, indicated the resident received three times per day safety checks, medication administration, and staff would manage behaviors including agitation,	0 630		

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0 630	Continued From page 7 anxiety, property destruction, repetitive behavior, self-injurious behaviors, sexual inappropriateness, substance abuse, and verbal aggression three times per day, as well as manage symptoms including other mental health needs and wandering three times per day. R1's February 19, 2024, assessment indicated the resident would visit the gas station in search of alcohol or drugs. The resident had a history of drug use and staff were to monitor for any signs and symptoms of drug overdoses. Interventions included observing for changes in behavior/cognitive status and report any to the nurse, approach her warmly and friendly and reassure the resident she is safe and secure. Staff were not to argue, dare, or debate the resident. The assessment indicated "NO drugs or alcohol allow on premises. ABSOLUTELY NOT!" The resident had a history of property destruction. Staff were to tell the resident "she should not destroy company properties as it is against the policy." The resident would bring visitors to the home to stay overnight. Staff were to "Inform client that visitor cannot stay overnight or shower in the bathroom Provide an accepting atmosphere, DO NOT SHOW SHOCK at the repetitive behavior..." The resident had a history of self-harm. Staff were to call 911 "if behavior is at crisis level." R1's record contained an incident report dated February 15, 2024, indicating the resident went to the gas station around midnight and "when she came back she started to talk a lot, but slurred and it was difficult to understand, then she was dropping stuff and struggle with balance..." 911 was called and the resident told officers she had used street drugs a few hours ago. The resident refused to go to the emergency room and went to	0 630		

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	36724	A. BUILDING: _____ B. WING _____	C 07/30/2024

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0 630	Continued From page 8 her room to go to sleep. The incident report lacked evidence it was reviewed by the RN. R1's record contained an incident report dated May 14, 2024, which indicated the resident's boyfriend called 911 after the resident became unresponsive. The incident report indicated the resident and her boyfriend "were in her room having a privacy then client choose go to the gas station. The client has a history of substance abuse, and the staff has been conducting daily monitoring to ensure her safety while in the facility. The client has the autonomy to leave the facility as she please. Sometimes the staff try to persuade the client not to go to the gas station but she typically refuses and asserts her right to go as she pleases. According to the employee and the boyfriend, the client went to the gas station alone late evening around 5pm on 5/14/24 and boyfriend was in the room during her returning. After 15 minutes the client was conscious and boyfriend called 911 for an assessment and transportation to the hospital for treatment...The police officer and paramedics checked and gave CPR, the officer inquired about the resident's most recent used street drugs..." The incident report lacked evidence it was reviewed by the RN. The police report indicated 911 was called on May 14, 2024, at 5:58 p.m. for a suspected overdose. Officers arrived 6:02 p.m. Narcan was administered, and the resident was taken to the hospital. Hospital records indicated the resident reported she had "smoked some Fentanyl and then does not remember what happened. Paramedics reported that they found the patient unresponsive...The patient does admit to using	0 630		

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0 630	Continued From page 9 meth regularly and using it today." The resident was evaluated in the emergency room and discharged back to the facility. R1's progress notes contained the following entries: -May 8, 2024, "Client was in a bad mood when I took over the shift he was very high with substance he didn't understand his self he was not well at all." -May 7, 2024, "When I got to work client was at home and doing okay. Later client left with her boyfriend and came back under the influence of drug. She could not stand nor even talked well. She was knocking things all around the place and it was just bad. Safety check was done and she is still very high. I could not give her her meds in the condition she is in. The overnight staff will give her her meds. I made dinner for client but client wasted all the food I made. Client is not in a good condition while I was still on my shift." -April 26, 2024, "Client been under the influence of drugs and been misbehaving the whole time. Her man is here and she she asked me to make food for she and her man. Safety check was done and the client is doing well. Client was so high and started knocking things all around here." -April 23, 2024, "Client is under the influence of some drugs and been misbehaving the whole time on my shift. I did her safety check and she doing fine. She been expecting her man the whole time,asked me to make food for she and her man. She been knocking things around the whole time. Client did not agreed to do her blood sugar again. Client took her 5pm and her 8pm meds."	0 630		

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0 630	Continued From page 10 -April 11, 2024, "When I got to work client was coming from the Tobacco shop and she was under the influence of drug and started misbehaving. I have to called my boss to report her. She later did her laundry, ordered her food and took all her med. I also did my safety check and she is doing great." -April 9, 2024, "This resident was doing well when I came in, later she left the house at 11pm and told staff that she ' s going to the gas station .She came back at 11:45pm and the mood was totally different. She was talking a lot, yelling at some point and laughing loudly and singing music that she had put in her phone. She has been up and down the house till 3am this morning is when she has gone to sleep." -February 16, 2024, "The client has a history of substance abuse and the staff has been conducting daily monitoring to ensure her safety while in the facility. The client has the autonomy to leave the facility as she please. Sometimes the staff try to persuade the client not to go to the gas station, but she typically refuses and asserts her right to go as she pleases. On 02/15/2024, client went to the gas station late at night and seemed to be under the influence of drugs or alcohol upon returning. She was speaking incoherently and having trouble staying steady on her feet. The client accidentally hit her head on the cabinet door but fortunately did not suffer any injury...The resident's unusual behavior prompted the staff to call 911 for an assessment and transportation to the hospital for further evaluation. Emergency services were called, and law enforcement arrived at the facility. Staff briefed the officers on the situation regarding the resident. The police officer checked the resident's blood sugar and it	0 630		

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0 630	Continued From page 11 was at a healthy level. The officer inquired about the resident's most recent use of street drugs, to which she replied it had been just a few hours ago. The facility recommended that the resident be taken to the hospital, but she refused. The officer and paramedics explained that they were unable to bring the client to the emergency room because she declined to go, and they cannot compel her to do so as it is within her rights. Therefore, they departed. The client was brought to her room, but she consistently returned to the common area. She tried to grab and hit the staff but was steered away. The client went back to her room and retired to bed. Resident will be monitored daily for safety and will call 911 if her behavior is at crisis level. Care plan will be updated to reflect changes in her behavior. A MAARC report of self-neglect was filed. Facility updated the case manager about the incident." On August 1, 2024, at 11:15 a.m., ULP-C stated the resident "had a lot of attitude, she was difficult." ULP-D stated the resident was "taking drugs almost every day, she was a tough client." ULP-D stated the resident was almost always "on something. She would be in the street walking, taking her clothes off." On August 1, 2024, at 11:35 a.m., ULP-D stated the resident had behaviors of abusing staff and was a difficult resident. ULP-D stated "nearly every day she was under the influence of drugs...she was always high." ULP-D stated she staff would call the nurse or manager to let them know and they would come over and check on the resident. On August 1, 2024, at 12:30 p.m., LALD-A stated the resident would use drugs about once a week or every other week and when she was using	0 630		

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0 630	Continued From page 12 drugs, "First, we'd have to talk to her and if she doesn't do any self-harm, we'd let her stay in her room and I used to call the case manager and the doctor sometimes I'd also call her boyfriend...then every 15 minutes we'd check her room until she's ok." LALD-A was asked if he felt the interventions in place were sufficient given the resident continued to use drugs while living at the facility. LALD-A stated, "She never used at our place, she'd go out...the case manager said they didn't' like my house rules, I don't have drugs in my facility, once she leaves she can do whatever she wants." LALD-A stated he had struggled with R1 because he had met "with the mental health case manager, the CADI case manager, they tell me the house rules are not acceptable, this person has the right, they're forcing me to let the boyfriend stay and spend the night...I don't want the issue of dealing with her getting mad, all my employees say they'll quit because of her." LALD-A stated, "We try everything... I talked to the case manager and they say she has the rights. What should I do then I used to call mental health for help and called a guy and he used to tell me "hey that's the system that's the way it is there's nothing you can do." There's nothing I could do about it I tried my best honest." LALD-A stated they had asked the resident's doctor to discontinue the methadone treatment she was on as it caused behaviors with the resident. On August 1, 2024, at 4:05 p.m., case manager (CM)-F stated the facility would frequently call her to complain about the resident due to her behavior or if they felt she was using too many resources from the facility. CM-F stated, "They were really over micromanaging things on her and causing problems by not supporting her with the areas of need...they never could get on board with understanding how to support her without	0 630		

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0 630	Continued From page 13 being punitive...They weren't following a plan for her I couldn't make any forward progress it was awful." CM-F stated the resident seemed to be doing better with methadone treatment and "I had never seen her so clear, she was really focused" but it did cause her to be more irritable and the facility suddenly said they wouldn't get her to treatment anymore and "they'd refuse or make it impossible or difficult for her to attend and at some point she stopped." CM-F stated the facility had said they would take the resident to her appointments but that did not always happen. CM-F stated the facility's treatment of the resident seemed to make things worse for her behaviors and drug use because she'd try to do things like cook but "they'd be right in there with her because the staff was upset because she has gross body movements like tardive and so she spills a lot. They were more irritated with her spilling and making a mess than her ability to cook independently. I'm trying to have a conversation with them to work towards independence and they keep inflecting more structure limiting her ability." CM-F stated the resident would often isolate in her room and would bring food down to her room so she didn't have to leave because "she had staff during the night verbally abusing her and she was hiding. She just said she didn't want to come out at night because she didn't want to make waves at some point she was isolating so hard some of that was a tipping point for when she started using [drugs] again." CM-F stated she wasn't immediately updated of R1's overdose but when she found out, "I mailed her Narcan because it's like I can't rely on the staff to protect her and when her house mate died [of an overdose], she was the one who responded to her she was traumatized by that." CM-F stated she would voice frustration to management over how they frequently called 911 for issues that they	0 630		

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0 630	Continued From page 14 should have been able to handle but "staff were sabotaging her ability to be there and they'd call 911 wanting her to be removed but 911 would show up and there wasn't an issue." CM-F stated she had a lot of frustration working with LALD-A because "he would blow up and storm out of the room" when they would meet to discuss R1's care and concerns with her care. On August 5, 2024, at 11:15 a.m., R1's mom stated, "I never received so many phone calls from her crying about what was going on there." R1's mom stated the resident would tell her about how another resident at the facility had put her head through a window and while she was on the phone with the resident, "numerous times he'd walk by and smack her in the head and she'd say don't hit me and I kept asking her what was going on." R1's mom stated the facility removed the bedroom door from her room and had a camera that pointed directly in her bedroom and the resident didn't have any privacy and it really upset her. R1's mom stated the facility did not update her on the overdose and she only found out after the resident called her. R1's mom stated, "I tried to reach out to [LALD-A] and I never ever got a phone call back, ever." R1's mom stated she kept telling the resident she needed to move out of the facility and find a safer place to live. On August 5, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-B was asked if he felt R1 was an appropriate placement for the facility and if the facility felt they could manage her needs before accepting her as a resident. CNS-B stated he did not do the preadmission assessment for the resident and that was completed by the owners of the facility who were not nurses. CNS-B stated he was told by the owners they had accepted a new resident and they needed him to come do the	0 630		

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0 630	Continued From page 15 admission assessment. CNS-B stated he knew the resident had a history of substance abuse and was "also very disruptive and uncooperative." CNS-B stated if the resident was observed to be under the influence of drugs, staff were to check her vitals and increase the number of safety checks to maybe an hour or every 30 minutes instead of the usual every two hours. CNS-B confirmed the facility did not document the increase in services for when the resident was under the influence. CNS-B stated it was known if the resident went to the gas station, it was likely she went out to do drugs and on the day she overdosed, staff should have noticed her coming back to the facility and assessed to see if she was under the influence. CNS-B confirmed an investigation was not completed after the resident's overdose but they did "ask the resident why she was using drugs and asked the case manager to take her to treatment." CNS-B stated the resident's "behavior, it's not easy when you're dealing with someone using drugs and they also say they make their own decisions on what they want to do. The staff can't force them to stop what they're doing." CNS-B was asked if the facility was appropriately staffed and trained to care for residents who are active drug users. CNS-B stated, "We are not good for managing people with drug use. I will not accept those kinds of patients to come to the facility again." CNS-B stated the resident chose to stop her methadone treatment because she frequently missed appointments. CNS-B stated the resident would take an uber or find a ride from someone go get to the appointments. On August 5, 2024, at 2:10 p.m., support specialist (SS)-G stated she began working with the resident after the facility raised concerns about the resident urinating in water bottles and	0 630		

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0 630	Continued From page 16 having increased behaviors. SS-G stated she met with the resident and asked why she was urinating in water bottles and she told her the overnight staff is a lot of times drunk and make inappropriate comments that were kind of sexual in nature and completely inappropriate and she was uncomfortable and didn't like leaving her room at night because she didn't feel safe so that's why she would pee in water bottles. SS-G stated LALD-A was aware as they had brought it up in a meeting but the employee was not immediately terminated. SS-G stated she had multiple concerns with the facility and felt like they didn't understand resident rights or assisted living regulations. SS-G stated she raised concerns with some restrictions they had for the resident and "I pointed these out and said you need to follow up with licensing. They had cameras in the house, one was pointed directly in her bedroom door and they had removed the door at one point, providing her no privacy." SS-G stated she had reviewed the resident's IAPP and "it wasn't good...it seemed like they typed it up the day they sent it to me." SS-G stated, "I think their approach to modifying some of those behaviors was less than what I would have liked to see. They really didn't seem like they were fully trained on the mental health aspect of what she's going through. They over utilized 911 I think there were a lot of calls to 911 and a lot of continued rules, which is almost a punishment in my perspective." On August 5, 2024, at 2:35 p.m., case manager (CM)-H stated she had many concerns related to abuse and neglect toward the resident while she was living at the facility. CM-H stated the resident "had been very unwell and started engaging in prostitution" in the facility. Owner (O)-I was aware of it because she would have her clients sign into the facility as a visitor and "he knew she was	0 630		

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0 630	Continued From page 17 engaging in prostitution so he asked her to not have her visitors sign in anymore" as she would sometimes have upwards of 14 people come in daily. CM-H stated the resident had told her LALD-A paid her hush money to not say anything about the facility and would pay her cash or send money via CashApp. On August 5, 2024, at 3:30 p.m. owner (O)-I stated, "We're doing our best, as you can see even before she came to us, look at her history, they're doing this a lot, they've overdosed how many times previously? We try to give them a chance and we are always the ones to blame even though we're doing the best we can...we know these people are mentally ill and at the end of the day, we're the ones blamed. I give every client a chance, we call the case manager we say we have to have one on one supervision, they don't want to provide it. They can't be watching all of them but they never do, they don't want to pay the money. We always tell them it's gonna be too late later on and they never do." O-I stated he was aware the resident had a history of drug abuse and a history of multiple overdoses when she admitted to the facility but he wanted to provide her with a second chance. O-I stated the resident was frequently under the influence while at the facility and the resident would "say she's going to the library and would come back all messed up, shaking all over and getting mad at everything. We told staff to give her space, just write down in a progress note if anything else happens or gets worse to call the nurse first and ask what they can do about it, if the nurse says call the police then we call the police." O-I stated staff were directed to check on the resident every 15 minutes while she was high but confirmed this was not documented anywhere. O-I stated the staff would "check on her and sometimes she	0 630		

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0 630	Continued From page 18 closes her door so I tell them knock on the door and if she answers, the leave. She always gets mad. She told me she's overdosed before a couple of times so that's why we always check on her all the time. She always screams in her room and hits her door or kicks it, it makes a lot of noise so you can tell." O-I stated on the day the resident overdosed, her boyfriend was there and "usually they have a lot of arguments...we go downstairs and say be quiet you guys make a lot of noise. I even talked to them through the camera and I said you make a lot of noise, we have a client upstairs then he said she overdosed." O-I confirmed there was a period of time where the resident did not have a door on her room as she had broken it. O-I confirmed the resident had a behavior where she would urinate in water bottles and stated it was likely because "she's too lazy to go to the bathroom. It's not possible she was afraid of the night staff. We only have two floors, she's in the basement. Staff stays on the first floor, they check on her then go back upstairs." O-I stated he was not aware the resident was prostituting herself and stated he never told her to not sign visitors in. O-I stated he used to see people coming in but he "wasn't sure if she was prostituting. I don't know about that." O-I stated the resident hallucinates sometimes and was not a reliable reporter. On August 16, 2024, at 10:15 a.m., R1 stated she had accidently overdosed after smoking some fentanly and all she could recall was that she laid down and "the next I know, I woke up in an ambulance." R1 stated the facility knew about her drug use but didn't really do anything. "They know what we're doing in the house, they're not stupid so they know, they're aware, they both are [LALD-A and O-I] but they just turn their backs."	0 630		

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0 630	Continued From page 19 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) Days.	0 630		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included within the residency agreement contract language which limited the rights of one of one resident reviewed (R1). This had the potential to affect all residents and visitors. 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 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: R1's record contained a six page document titled "House Rules." The document indicated "The House Rules is a document that sets forth how the agency defines the behaviors associated with good rental and client's conduct...House rules are a part of or an addendum to the client's lease	02290		

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	36724	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPFUL HANDS HOME CARE LLC	6712 DREW AVENUE NORTH BROOKLYN CENTER, MN 55429

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02290	Continued From page 20 agreement. The agency reserves the right to make changes, amendments, or adopt additional house rules as needed. The house rules will be equally enforced. Failure to comply with the house rules will constitute a material breach of this agreement and my constitute a just cause for services and lease termination." The house rules included six points for transportation including "there will be two outings per week for everyone who would like to participate. The management staff will schedule them. Any extra outings will need prior approval by the management team" and "client cannot exhibit verbal or physical outbursts, temper tantrums, and unwanted movements when in vehicle or being transported. Staff will pull over to a safe location until behavior stops and everyone is quiet." There were 15 points for communication including "client's communication should be as clear as possible to ensure their needs are met", a chain of command was to be followed to communicate with nurses, and that phone calls using the facility phone were to be "limited to blocks of 15 minutes per hour." Quite time began at 11:00 p.m. There were 16 points for "bedroom" including "client's room door should remain unlocked during the night hours while asleep for staff to complete safety checks," visitors were only allowed until 10:00 p.m., visitors were not allowed to sleep or shower in the facility, "all clients are to sleep in his/her bedroom and not in common area, and "clients are allowed to cook only with staff's supervision." There were 18 points for conduct including "all musical instruments, television sets, stereos, radios, etc., are to be played at a volume which cannot be heard outside client's room." No alcoholic beverages or illegal drugs were allowed on the premise and residents could not consume any alcohol in the property. No overnight guests were allowed at any time. If a resident left the facility,	02290		

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02290	Continued From page 21 they were required to "sign themselves out and notify staff of their plans, including places they will be visiting or going to, time of departure, and estimated time of return. Please notify staff at least 24 hours in advance to facilitate adequate planning especially medication set-up...clients must leave a phone number where they can always be reached." Another rule indicated "no client is allowed to claim refrigerator space as his/her own. Client can purchase his/her own mini-refrigerator that is FDA approved for the room." Residents were prohibited from keeping hunting knives or other knives in their room. The house rules included five points for general behaviors which indicated "no physical aggression, assault or violence is allowed at this facility...no provoking or taunting peers or staff negatively." One rule indicated "all abusive, disorderly, violent, or harassing conduct by a client, including but not limited to abusive and/or foul language, sexually explicit comments towards peers or staff is prohibited and is ground for immediate dismissal or discharge from facility." R1 signed the house rules on February 10, 2024, and agreed they had "received these House Rules, that I have had a chance to read them, and that I understand them. I understand that these House Rules are a part of my lease and services agreements, and I fully abide by all the requirements of these House Rules." On August 1, 2024, at 12:30 p.m., LALD-A stated the facility used house rules as the resident had a history of drug use and they did not allow drugs to be used in the facility. LALD-A stated he had been told by the resident's case manager that they did not like his house rules.	02290		

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02290	Continued From page 22 On August 5, 2024, at 3:30 p.m. owner (O)-I stated the house rules were for all residents and implemented after a disruptive resident who no longer lived at the facility. O-I stated since that resident was no longer there, they shouldn't have house rules anymore. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and individual person(s) were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	
02400 SS=D	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family,	02400		

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02400	Continued From page 23 guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect the one resident (R1) at the facility. 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 situation has occurred only occasionally). The findings include: R1's diagnoses included depression, opioid use disorder, substance abuse, anxiety, bipolar 1 disorder, and post traumatic stress disorder (PTSD). R1's service plan dated January 1, 2024,	02400		

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02400	Continued From page 24 indicated the resident received three times per day safety checks, medication administration, and staff would manage behaviors including agitation, anxiety, property destruction, repetitive behavior, self-injurious behaviors, sexual inappropriateness, substance abuse, and verbal aggression three times per day, as well as manage symptoms including other mental health needs and wandering three times per day. R1's record contained a document titled House Rules, which she signed on February 10, 2024. The house rules indicated visitors could stay until 10:00 p.m. and visitors were not allowed to sleep at the facility. A progress note indicated on February 28, 2024, "A meeting was held with two case managers and the staff at the facility to address the resident's behavior and the increased incidents whereby the police has been called several times to intervene...The resident agreed to be to follow the house rules regarding visitors, disruptive behaviors, aggressive and self injurious behaviors, property destruction and self-neglect....The resident accepted that she will have her boyfriend visit at least 2 nights per week and that she will notify the staff when she brings a visitor for the night...." On August 5, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated the resident would have her boyfriend over every day and they had to meet with the resident and her case managers and "we allowed her boyfriend to come three times per week, he couldn't come every day." CNS-B added, "We didn't restrict him from coming but it was so frequent and he was coming through the window that we said it was ok for him to come three times a week." CNS-B was asked	02400		

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02400	Continued From page 25 how that would not be restricting her visitation and stated, "I know residents have a right to have visitors at all times." On August 5, 2024, at 3:30 p.m. owner (O)-I stated "You know her boyfriend is with her all the time, he's been with her like every single day and we talked to her case manager and complained about that and they said it's ok for him to stay there and we had a meeting with us and the case manager and [the resident] and they said it's ok he can come any time, he can stay a couple nights a week. It was too much for us even then, we don't know what he's going to bring to her, he can bring anything he's a drug abuser we don't know what he's bringing to her." On August 16, 2024, at 10:15 a.m., R1 stated the facility had actually called the police twice and had her boyfriend removed after he came to visit and it wasn't until a case manager got involved that the facility finally agreed to allow more open visitation. The Minnesota Bill of Rights for Assisted Living Residents, last updated November 8, 2022, indicated residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. In addition, the resident has the right to meet with or receive visits at any time from the resident's family, guardian, conservator, health care agent, attorney, advocate, religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.	02400		

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02400	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02400		