Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL367249046M
Compliance #: HL367246637C

Date Concluded: May 3, 2024
Date Revised: May 13, 2025

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator
Amended By: Matt Heffron, JD, EMT
Operations Manager

Finding: Substantiated, facility and individual 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 the facility staff failed to supervise the resident with a known drug abuse history. The resident overdosed and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and alleged perpetrator (AP)~~1 and~~ AP2 were responsible for the maltreatment. Although multiple facility staff had knowledge of the resident's substance use history, adequate interventions were not in place to address that issue. ~~AP1, a facility owner and the licensed assisted living director, had knowledge of the resident's drug abuse history and directly supervised the unlicensed personnel (ULP). AP1 failed to address ULP concerns regarding the resident sleeping in the garage, unsupervised. AP1 failed to direct ULP to execute interventions identified in the facility's behavior policy.~~ AP2, the clinical nurse supervisor, failed to develop individualized

safety interventions with specific instructions for staff to monitor for self-injurious behaviors, drug use and safety checks. As a result, the resident lived in the facility garage for four months, continued to abuse drugs, overdosed, and died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the case worker, and a family member. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policies and procedures. The investigation also included review of the MDH surveyor notes at the time of the incident. Also, the investigator observed the facility garage.

The licensee policy titled Behavior Plan, indicated staff would monitor signs leading to self-injurious behaviors, conduct spot checks with regards to resident safety, search the licensee for illegal storage of contraband, and encourage residents not to partake in drinking and drug use.

The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder, major depression, and methamphetamine use disorder. The resident's service plan included assistance with behavior monitoring and medication administration. The resident's assessment indicated the resident walked independently and was alert and oriented.

The resident's assessment, $_{CO}$mpleted by AP2, indicated the resident had impaired recall, judgement, and occasional unsafe behavior of wandering while intoxicated. The assessment indicated the resident admitted to the facility with known drug use history and was at risk of becoming incoherent and disoriented when under the influence.

The resident's individual abuse prevention plan (IAPP), developed by AP2, indicated the resident's environment was always safe and clean. The IAPP inaccurately indicated the resident was not at risk for self-abuse and did not smoke. The IAPP indicated the resident was at risk for substance abuse due to her history and indicated interventions of the resident included not allowing her to use alcohol or drugs at the facility and staff to report to nurse any use. The IAPP failed to provide specific instructions for monitoring the resident's behavior, preventative measures to deter the resident from substance abuse, and instructions for staff on how to execute interventions as stated in the Behavior Plan policy.

The MDH surveyor onsite notes indicated the surveyor conducted an unrelated investigation a week prior to the resident's death. While onsite, ULP 1 stated the resident went to the garage to smoke due to not being allowed to smoke in the facility. The surveyor interviewed the resident related to her witnessing an incident involving another resident. During the interview, the resident referred to the garage being her smoke and craft room.

A law enforcement (LE) report indicated the resident had previously left the facility and placed herself in a homeless shelter due to not feeling safe at the facility. Facility staff brought the resident her medications to her at the shelter. The report indicated the resident notified the facility staff she moved to the shelter because she did not feel safe at the facility due to the behavior and actions of another resident of the facility.

During an interview, a mental health worker stated the resident told her she stayed in the garage out of fear, and AP1 gave the resident permission to live in the garage. The mental health worker stated the resident was living in the garage full time, and she would always have to wake the resident up in the garage for their scheduled 8:00 a.m. appointments.

One morning, ULP 1 attempted to bring the resident her medications in the garage where she was located but noted the door locked from the inside. The resident did not answer the door. An hour later, ULP 1 returned to the garage and gained entry. ULP 1 noted the resident sleeping on the mattress that was on the floor. Two hours later, ULP 1 entered the garage and noted the resident was still lying on the floor and was not responsive. The resident had a foamy discharge coming from her mouth. ULP 1 summoned emergency medical services (EMS) while another facility resident initiated cardiopulmonary resuscitation (CPR). EMS staff continued the CPR, but eventually pronounced the resident deceased.

The resident's hospital record indicated the resident had four emergency room visits for substance abuse induced medical concerns in the months prior to her death.

A LE report indicated on the day of the resident's death, another facility resident had administered two doses of Narcan (a medication used to treat a narcotic overdose in an emergency) and initiated CPR to the resident prior to LE arriving. LE noted a large amount of drug paraphernalia and a white powder substance on a table and a mattress in the garage.

Review of the LE photographs of the garage showed a bed mattress on the floor with pillows and a blanket, the resident's purse, drug paraphernalia such as a torch lighter and pipe, personal hygiene items placed in bins on shelves next to the mattress, bottles of water, clothing, an operating TV and remote, a couch facing the TV, a portable heater, food items and condiments, and a tent like structure hanging from the garage ceiling over the couch.

The resident's death record indicated the cause of death was mixed drug toxicity that included gabapentin (an anticonvulsant), methadone (an opioid medication), and methamphetamine (a highly addictive illegal drug stimulant).

The National Association of Drug Diversion Investigators (NADDI) website included glossary information on the drug classification of Gabapentinoids, which includes gabapentin. NADDI indicated when ground up and snorted, the drug can produce a cocaine-like high. In addition, the drug can increase the effects of other opioids.

During an interview, ULP 1 stated she checked on the facility residents once a shift and could tell if the resident was using drugs by how she acted. ULP 1 stated if there were resident concerns, she would contact AP1.

During an interview, ULP 2 stated he checked on the residents twice a shift as required. ULP 2 stated he met with AP1 on three occasions about the resident living in the garage and AP1 did not do anything about it. ULP 2 stated the resident lived in the garage for four months.

During an interview, AP1 stated the resident was a reliable reporter. AP1 stated the resident admitted to the facility with a known drug abuse history. AP1 stated he spoke to the resident about her drug problem, and the resident stated she knew AP1 was going to help her. AP1 stated when symptoms of drug use were present, he attempted to have the resident go to the emergency room, but she would refuse. AP1 denied seeing the resident use drugs on the property. AP1 stated he could tell when the resident was under influence by her behavior. AP1 denied the resident slept in the garage. AP1 was not able to identify safety interventions in place for the resident.

During an interview, AP2 stated he assessed the resident every ninety days and with any change of condition. AP2 stated staff offered the resident assistance for drug abuse treatment, but the resident refused and did not want treatment. AP2 was not able to identify safety interventions in place for the resident. AP2 denied the resident expressed concern for her safety and denied being aware of why the resident admitted herself into a homeless shelter.

During an interview, the facility's second owner stated staff check on residents as the residents allow. The owner stated he expects the residents' assessments accurately reflect the needs of the resident. The owner acknowledged the resident's assessments were not accurate, and the resident was at risk for abuse. The owner denied having knowledge of the resident having any safety concerns. The owner stated the resident never slept in the garage.

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: No, deceased.
Family/Responsible Party interviewed: No. Did not return request for interview.
Alleged Perpetrator interviewed: Yes, AP1 and AP2.

Action taken by facility:
No action taken.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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
MN Board of Nursing
MN Board of Executives for Long Term Services and Supports

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 03/19/2024

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****** AMENDED 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: #HL367246637C/#HL367249046M On March 19, 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 were two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL367246637C/#HL367249046M, tag identification 330, 2360. On May 13, 2025, the correction order with tag identification 2360 was amended to indicate one alleged perpetrator instead of two individuals responsible for the substantiated maltreatment.	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.	

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0 330	Continued From page 1	0 330		
0 330 SS=G	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide truthful information during the investigation for 1 of 1 resident (R1) reviewed. The licensee staff falsely reported R1 was not sleeping in the facility garage when evidence and law enforcement photographs demonstrated she was. 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 generalized anxiety disorder, major depression, and methamphetamine use disorder. R1's service	0 330		

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0 330	Continued From page 2 plan dated October 13, 2021, indicated R1 received behavior monitoring and medication administration. R1's indiviual abuse prevention plan (IAPP) dated October 13, 2021, indicated R1 did not smoke. The IAPP indicated R1 may not use alcohol or drugs while residing at the facility but lacked documentation of interventions related to R1's known drug abuse stated in the IAPP. The IAPP indicated R1 was not at risk for abuse from others. A law enforcement (LE) report dated February 9, 2023, indicated R1 moved into a homeless shelter due to being afraid of another resident (R2) who resided at the facility. The report indicated LE spoke to owner (OW)-G, OW-D, and unlicensed personnel (ULP)-A. All three of them reported to LE facility residents were in fear of R2. Additionally, the report indicated R1 told facility staff she was in fear for her safety at the facility. A LE report dated October 24, 2023, indicated the LE officer noted several couches, a bed mattress and a television in the garage, that indicated to the officer the space was frequented often by R1. The report indicated the officer noted a large amount of drug paraphernalia items and a white powder substance on a table and on the mattress in the garage. The report indicated OW-D reported R1 had been going to drug treatment. LE provided photos dated October 24, 2023, indicated the presence of a bed mattress with pillows on the garage floor, a couch, a television, various personnel items such as grooming	0 330		

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0 330	Continued From page 3 supplies, cigarettes, food and drinks, and a make shift tent like structure hanging from the ceiling present. During an interview on March 19, 2024, at 10:56 a.m., ULP-A stated R1 was a reliable reporter and told the truth. ULP-A denied having any knowledge of R1 being in fear of her safety. ULP-A stated R1 would go to the garage to smoke and denied R1 slept in the garage. During an interview on March 22, 2024, at 8:00 a.m., a mental health case manager (CM)-B stated R1 brought concerns to her on a regular basis. CM-B stated R2 assaulted R1 and facility staff reported the incidents to the police. R1 told CM-B she stayed out in the garage in fear for her safety. CM-B stated R1 was living in the garage full time and she had seen drug paraphernalia many times in the garage while she visited R1. CM-B stated she would have to wake R1 up in the garage for their 8:00 a.m. appointments. During an interview on March 22, 2024, at 2:00 p.m., ULP-C stated OW-D and OW-G knew about the R1's drug use and did nothing about it. ULP-C stated R1 was living in the garage for four months. ULP-C stated he had three meetings with OW-D and OW-G to voice concern about R1 living in the garage. During an interview on March 25, 2024, at 10:00 a.m., OW-D stated R1 was a reliable reporter. OW-D denied other residents abused R1. OW-D stated they offered R1 drug abuse treatment, but R1 refused to go to any treatment. OW-D stated R1 only went in the garage to smoke cigarettes and denied R1 lived in the garage.	0 330		

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0 330	Continued From page 4 During an interview on March 27, 2024, at 2:50 p.m., R3 stated R1 would be awake out in the garage all night. R3 stated R1 pretty much lived in the garage. During an interview on March 28, 2024, at 2:05 p.m., OW-G stated R1 smoked and was at risk for abuse. OW-G stated R1 never used drugs in the garage. OW-G stated the R1 did not express any concerns to him and liked it at the facility. OW-G stated the staff locked the garage at 5:00 p.m. every day and did not open it again until around 12:00 p.m. the next day. OW-G denied R1 slept in the garage. TIME PERIOD FOR CORRECTION: 2 days	0 330		
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 resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual 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.	