Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL386168986M
Compliance #: HL386166624C

Date Concluded: April 11, 2024

Name, Address, and County of Licensee Investigated:

Happy Care Inc
6703 89th Avenue North
Brooklyn Park, Minnesota 55445
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, 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 alleged perpetrator (AP) neglected resident 1 when he left resident 1 at the facility to buy groceries. Resident 1 called 911 due to not feeling well and was transferred to the emergency department (ED) for evaluation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated for resident 1. The AP was responsible for the maltreatment. The AP knowingly left resident 1 at the facility without another staff member present. Resident 1 had a change in condition and required medical care. Resident 1 called 911 and went to the hospital. The hospital staff diagnosed resident 1 with diabetes and sepsis (a life-threatening medical emergency in which the body has a response to an infection that can cause organ failure and death).

The Minnesota Department of Health determined neglect was inconclusive regarding the facility's responsibility. The facility lacked documentation of any possible symptoms resident 1 may have had prior to the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, resident 1's hospital record, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed current staffing at the facility.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included a brain injury and seizure disorder. Resident 1's service plan included medication administration, bathing reminders, meals and assistance with shopping as needed. Resident 1's assessment identified the resident as alert and oriented.

Resident 2's diagnoses included a mental health disorder. Resident 2's received housing only service. Resident 2's service plan indicated resident 2 was independent with cares, safety, and medication administration. Resident 2's assessment identified resident 2 as alert and oriented.

A progress note indicated resident 1 requested the AP purchase him some fruits and snacks from a nearby grocery store. The AP asked resident 1 to ride with him to the store. Resident 1 declined and stated he would stay with resident 2. At this time, resident 1 denied any concerns of feeling unwell and appeared comfortable. Within 15 minutes of the AP leaving the facility, resident 1 called 911. Law enforcement arrived and called the AP. Emergency medical services (EMS) brought resident 1 to the hospital for evaluation.

A law enforcement report indicated resident 1 called 911 due to not feeling well. Resident 1 could hardly walk and felt very weak. The report indicated a law enforcement officer spoke with the AP on the phone. The AP could not explain why there were no staff present, but he was on his way back. About 45 minutes after the 911 call, the AP returned to the facility. Resident 1 reported the AP left the facility about 15 minutes before he called 911, so resident 1 had been left at the facility unsupervised for at least one hour.

An ambulance run report indicated resident 1 stated he had been feeling ill for multiple days, with increased weakness, thirst, and frequency of urination. EMS transported resident 1 to the hospital.

Resident 1's hospital record indicated resident 1 presented with a blood glucose level of 903, as well as several weeks of weight loss, increased thirst and urination, blurred vision, and a general feeling of unwell. Resident 1's hospital diagnoses included diabetes and sepsis. Resident 1 admitted to the hospital for four days before he was discharged back to the facility with new orders related to diabetes management and antibiotics for sepsis.

Resident 1's medical record lacked progress notes or other documentation prior to the incident identifying resident 1's symptoms. Three nursing assessments, including the assessment prior to the incident, the post-hospitalization assessment, and the most current assessment, failed to include resident 1's weight.

During an interview, the registered nurse (RN) stated resident 1 did not complain of feeling unwell prior to the incident. The resident did not have a diagnosis of diabetes until this hospitalization. After this incident, the RN and licensed assisted living director (LALD) held a quality assurance meeting and completed education with the AP, who was the owner of the facility.

During an interview, resident 1 stated the AP left the facility to buy groceries he requested. Resident 1 tried to get up to use the bathroom. He could not open the door at first because his body "locked." When he did get the door open, resident 1 could not unfasten his pants, so he yelled for resident 2. Resident 2 came to his room, and he instructed her to call 911. When EMS arrived, they tried inserting an intravenous (IV) line. They could not find a vein, so they eventually had to insert one in his foot. At the hospital, he had a blood glucose level of 900.

During an interview, resident 2 stated resident 1 yelled for her from his room. Resident 2 went check on resident 1 who asked her to call 911. Both residents went to the front porch to wait for EMS. There were no staff present at the facility. An officer arrived, and resident 2 gave her phone to him to call the AP. Later, resident 2 told the AP a staff person needed to be at the facility when residents were there.

During an interview, the AP stated resident 1 asked him to get groceries from the store. The AP asked resident 1 to ride with him, but resident 1 declined and stated he would stay with resident 2. Resident 1 seemed normal and appeared to be comfortable. The AP left, and within 15 minutes, resident 1 called 911. In the days and weeks leading up to the incident, the AP stated resident 1 did not complain about not feeling well and had been in a good mood. Prior to this incident, the facility had not been aware of a diabetes diagnosis. Since this incident, resident 1 has returned to his baseline health, aside from the new diagnosis of diabetes. Additionally, the AP stated he had not left resident 1 alone at the facility since this occurred.

Resident 1's service delivery records indicated between the AP and one other unlicensed personnel; one staff covered 24 hour shifts to provide resident 1's services over seven weeks. The AP provided 24 hour shifts up to 11 days in a row. The AP, the owner of the facility, had control over scheduling and hiring staff to provide adequate staffing.

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.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: Not Applicable. Resident is his own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The RN completed an assessment and updated the service plan after the resident returned from the hospital.

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 Park City Attorney
Brooklyn Park 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
	38616	A. BUILDING: _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY CARE INC	6703 89TH AVENUE NORTH BROOKLYN PARK, MN 55445

(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: #HL386166624C/#HL386168986M On February 22, 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 1 resident receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL386166624C/#HL386168986M, tag identification 0470, 2360.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure adequate staffing to meet the scheduled and unscheduled needs of one of two residents (R1) and to provide awake staffing. This affected all residents. 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	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death) 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). The findings include: Owner (OW)-C started working at the licensee September 23, 2021. Unlicensed personnel (ULP)-D started working at the licensee April 17, 2023. R1's diagnoses included a brain injury and seizure disorder. R1's service plan dated May 23, 2023, indicated R1 received assistance with bathing reminders, meals, medication administration, and shopping as needed. R1's nursing assessment dated January 13, 2024, identified R1 as alert and oriented. R1's service delivery record, from January 1, 2024 through February 21, 2024, indicated only OW-C and ULP-D provided cares. OW-C initialed every service provided for the morning (A.M.), evening (P.M.), and overnight (NOC) shifts (24 hour shifts) on the following dates: January 1, 2024, January 3, 2024, January 5, 2024, through January 7, 2024, January 9, 2024, through January 20, 2024, January 22, 2024, through January 23, 2024, January 26, 2024, through January 28, 2024, February 2, 2024, through February 4, 2024, February 9, 2024 through February 13, 2024, February 15, 2024 through February 18, 2024.	0 470		

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0 470	Continued From page 3 ULP-C initialed every service provided for the A.M., P.M., and NOC shifts (24 hour shifts) on the following dates: January 2, 2024, January 4, 2024, January 8, 2024, January 24, 2024, through January 25, 2024, January 29, 2024, through February 1, 2024, February 5, 2024 through February 8, 2024, February 14, 2024, February 19, 2024 through February 21, 2024. During an interview on February 22, 2024, OW-C stated he would only sleep a little on a shift if R1 had already taken his medications and allowed OW-C sleep. OW-C stated the week of the onsite was the only week OW-C was scheduled multiple shifts and days in a row because a staff member quit. During an interview on March 21, 2024, at 12:00 p.m., OW-C stated R1 received supervision 24 hours per day, seven days per week. During an interview on March 22, 2024 at 10:03 a.m., licensed assisted living director (LALD)-A stated the licensee needed to have an awake overnight staff. LALD-A stated at the time of the interview, it was acceptable to only have two staff members because the licensee only had one resident. LALD-A stated they were in the midst of recruiting and were currently training back up staff. During an interview on March 22, 2024 at 12:25 p.m., registered nurse (RN)-B stated OW-C stated his plan was to hire another staff person when he got another resident. RN-B stated it was not acceptable for one staff member to be the only staff member for multiple shifts and days at a	0 470		

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0 470	Continued From page 4 time. The licensee's policy titled Staffing, dated March 29, 2023, indicated the RN would have prepared and implemented a 24-hour daily staffing plan which ensured adequate staffing to meet residents' needs at all times. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 470		
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 an individual person was 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.	