Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356392809M
Compliance #: HL356394759C

Date Concluded: June 23, 2023

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
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):

Allegation #1: The facility neglected to provide appropriate care and services when a resident reported staff left the facility residents alone and failed to protect the resident from a peer who pulled a gun on him.

Allegation #2: The facility neglected a resident when they failed to reorder his medications or transport the resident to pick up his medications, which resulted in the resident not receiving his insulin.

Allegation #3: The alleged perpetrator (AP), a facility staff, neglected a resident when the AP gave the resident a peer's medication resulting in hospitalization.

Investigative Findings and Conclusion:

Allegation #1: The Minnesota Department of Health determined neglect of care (regarding staffing and threatening peer) was inconclusive. The allegation provided no specific timelines. The facility scheduled staff 24 hours per day. There was no evidence of staff leaving the facility residents alone. The facility documentation indicated they investigated the report of a gun and offered the resident alternative living options until the peer moved. There was no evidence of a gun in the facility.

Allegation #2: The Minnesota Department of Health determined neglect (related to ordering medications) is inconclusive. The facility documentation did not indicate absence of insulin supply. The facility, however, failed to follow their medication management policy.

Allegation #3: The Minnesota Department of Health determined neglect (related to the medication error) was not substantiated. Although the resident received a peer's medications in error, it was an isolated incident, the AP recognized the error, contacted the nurse, and the resident went to the hospital. The resident had no lasting effects from the medication error but stayed in the hospital for two nights for monitoring of blood pressure and blood glucose.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager. The investigation included review of medical records, personnel file, incident reports, staff schedules, policies, and procedures related to medication management, medication errors, medication prescriptions, provision of services, delegation of nursing tasks, treatments, therapy, and reporting of maltreatment of vulnerable adults. Also, the investigator observed staff and resident interactions, medication room, and were present when the resident checked his own blood sugar.

The resident moved into the assisted living facility for assistance with medication (including insulin) and for coordination of appointments, due to a history of lack of permanent housing. The resident required establishment with a primary care provider for medications and services for medication management. The resident's medication management plan indicated the nurse set up the resident's medications for unlicensed staff to administer. The facility medication management service included reordering medications.

The resident's medication administration record indicated, although the resident had refused medications at times, including insulin, there were no documented incidents of lack of medication supply.

During an interview, the nurse stated she reordered the resident's medications and someone from the facility would pick it up from the pharmacy. A managerial staff, nurse, director of nursing, or unlicensed staff would pick up the medication.

During an interview, the resident stated he did not get his pills sometimes, but also that he had times when he did not want to take his medications. The resident stated the facility called the

pharmacy to get refills, and staff were supposed to pick them up. The resident stated he had recordings of medication infractions but unable to provide them to the investigator.

An incident report indicated the AP gave the resident a peer's medications, the resident went to the hospital and returned two days later.

During an interview the AP stated she took the resident's medication, which was set up by the nurse in a pill pack, from the storage room and set it on the table. The AP stated the peer and peer's guest distracted her and she put the pill pack down. The AP stated she went back to the pill pack, opened the correct day, and gave the resident the contents. The staff stated shortly after the resident swallowed the pills, he asked about a red pill he did not see. The AP looked down to see another pill pack on the table and realized she gave the resident the peer's pills. The AP stated she called the nurse, who instructed her to take the resident's vital signs and wait for the nurse to arrive to assess the resident. The AP stated the resident called a friend while waiting for the nurse and the friend called 911. The nurse arrived about the time the ambulance arrived, and the resident went to the emergency room. The AP stated the facility nurse had required medication administration retraining before she was able to administer medications again.

During an interview, the resident stated he did not realize he took the peer's medications, but when looked at the pill pack, saw that it was peer's medications. The resident stated he started feeling sweaty and his friend called the ambulance. The resident stated he does not like taking medications when the AP is working.

In conclusion, neglect of care (regarding staffing and threatening peer) was inconclusive, neglect of care (regarding reordering medications) was inconclusive, and neglect (related to a medication error) was not substantiated.

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.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable

adult; and
(2) which is not the result of an accident or therapeutic conduct.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, as the resident was his own guardian.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided medication administration retraining to the AP.

Action taken by the Minnesota Department of Health:

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35639	A. BUILDING: _____ B. WING _____	C 05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HEALTH & HOME CARE SERVICES INC	4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: #HL356394759C #HL356392809M On May 30, 2023, 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 three residents receiving services under the provider 's Assisted Living license. The following correction orders are issued for #HL356394759C #HL356392809M tag identification 0620, 1880, 2310, and 3000.	0 000	Assisted Living Provider 144G. 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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0 620	Continued From page 1	0 620		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) a medication error for one of one resident (R1) reviewed when an unlicensed staff person (ULP)-B gave R1 medications meant for another resident as a result R1 was hospitalized. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Review of R1's medical record indicated R1 lived in an assisted living with diagnoses including insulin dependent diabetes mellitus and traumatic brain injury. R1's Assessment document dated June 22, 2022, indicated R1 required full medication management including medication set-up.	0 620		

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0 620	Continued From page 2 An Incident Report dated January 24, 2023, indicated ULP-B gave another residents medication to R1 when the other resident left her own pill pack on table. ULP-B administered the medications from the pill pack to R1. R1 was sent to emergency department for evaluation. A hospital record dated January 24, 2023, indicated R1 had accidental ingestion of multiple unknown medications after being given medications in error. The case was discussed with poison control and R1 was admitted for observation of blood sugar and blood pressure for two days then returned to the facility. During interview on May 30, 2023, at 10:49 a.m., ULP-B stated she gave R1 another residents medications in error. ULP-B stated she immediately called director of nursing (DON)-C to report a medication error. DON-C directed ULP-B to check R1's vital signs which were in normal range. ULP-B stated DON-C was on her way to the facility to assess R1 in person, however R1's friend contacted 911 before DON-C arrived. ULP-B stated the paramedics transported R1 to the hospital for evaluation. ULP-B did not make a report to MAARC. During interview on May 31, 2023, at 12:00 p.m., licensee assisted living director (LALD)-A stated the licensee should have filed a report to MAARC when R1 was administered another residents' medications in error. Reporting Maltreatment of Vulnerable Adult Policy (undated) indicated that all or suspected cases of adult maltreatment are reported. Emergency Procedure/911 Calls Policy (undated)	0 620		

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0 620	Continued From page 3 indicated the registered nurse would contact MAARC immediately (no later than 24 hours) if the incident is reportable under the Vulnerable Adult Act TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to securely store medications for one of one resident (R1) reviewed for medication errors when the facility placed R1's insulin and injectable antidiabetic medication in an unlocked food refrigerator which anyone entering the facility had access to. This had the potential to impact 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 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:	01880		

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01880	Continued From page 4 Review of R1's medical record indicated R1 lived in an assisted living facility with diagnoses including insulin dependent diabetes and a traumatic brain injury. R1's Master Care Plan document dated May 18, 2023, indicated R1 required assistance with blood sugar checks only with staff monitoring the blood glucose log. The document indicated R1 had "a tendency to refuse blood sugar checks and refuses to take his insulin." R1's Individualized Medication Management Plan dated May 18, 2023, indicated all medications would be secured in a locked medication room and only staff would have access to the medication. During observation on May 30, 2023, at 9:12 a.m., the investigator saw multiple boxes of injectable medications prescribed to R1 (Bydureon (antidiabetic), Lantus (insulin) and Lispro (insulin) in an unlocked community refrigerator. The medication was accessible to all residents and anyone entering the facility. In addition, the insulin was stored in the same refrigerator with food and drinks. During an interview on May 30, 2023, at 9:41 a.m., licensed assisted living director (LALD)-A confirmed R1's insulin and antidiabetic injection were stored in a refrigerator outside of the medication storage room. The Medication Set Up policy (undated) indicated all medication should be stored in the facility in a safe and secure location. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services for one of one resident (R1) reviewed for medication management. R1 independently checked blood sugars, independently set the dose on the prefilled insulin pen, and injected his own insulin, contrary to R1's care plan, medication management plan, and individual abuse prevention plan. In addition, the licensee failed to ensure documentation of medication management activities. This had the potential to harm R1, who frequently refused his medications, including insulin. 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 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: Review of R1's medical record indicate R1 lived in an assisted living facility with diagnoses that included insulin dependent diabetes mellitus and	02310		

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02310	Continued From page 6 traumatic brain injury. R1's Assessment document dated June 22, 2022, indicated R1 required full medication management and set-up, and "med[ication] self-admin[istration] is not applicable." R1's Individual Abuse Prevention Plan document dated July 8, 2022, indicated R1 required assistance with blood sugar checks only and R1 required full medication management and setup. R1's Individualized Medication Management Plan document dated July 8, 2022, indicated R1 required full medication management and setup. The document indicated R1 "does not self-admin[ister]" medications. R1's Master Care Plan document dated May 18, 2023, indicated R1 required assistance with blood sugar checks with staff monitoring the blood glucose log. The document indicated R1 had "a tendency to refuse blood sugar checks and refused to take his insulin." The document failed to include specific instructions relating to R1's insulin and other injectable medication. R1's Individualized Medication Management Plan document dated May 18, 2023, indicated R1 was increasingly becoming non-compliant with taking medications. The document indicated R1 "does not self-admin[ister]" medications. The document failed to include specific instructions relating to R1's insulin and other injectable medication. R1's Individual Abuse Prevention Plan document dated May 18, 2023, indicated R1 required assistance with blood sugar checks and R1 required full medication management and setup. The document indicated R1 increasingly	02310		

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02310	Continued From page 7 becoming non-compliant with taking his medications. R1's Assessment document dated May 18, 2023, indicated R1 received assistance with blood sugar checks and had a "tendency to refuse blood sugar checks" and refused to take his insulin. The assessment indicated R1 was increasingly non-compliant with taking his medications, refusing and skipping doses, and indicated "client does not self-admin[ister medications]" R1's Current Medications document dated May 30, 2023, indicated R1's primary physician's prescriptions included the following medications: Bydureon (an antidiabetic injectable medication) 2 milligrams (mg)/0.85 milliliters (ml), inject 0.85 ml subcutaneously (under the skin) once a week (Friday). Humalog (insulin lispro) 100 units/ml, inject 38 units under the skin three times daily before meals (8:00 a.m., 12:00 p.m., and 8:00 p.m.) Lantus Solostar (insulin) 100 units/ml, inject 80 units under the skin two times daily 12 hours apart (8:00 a.m. and 8:00 p.m.) R1's progress notes dated July 1, 2022, through May 30, 2023, lacked evidence of documentation of communication with the pharmacy, medication set ups for leaves of absence, or blood sugar checks. During an interview on May 30, 2023, at 9:15 a.m. unlicensed personnel (ULP)-B stated the nurse set up R1's pills, but R1 checked his own blood sugar levels, independently sets the dose on the prefilled insulin pen, and injected his own insulin. During an interview on May 30, 2023, at 4:00 p.m.	02310		

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02310	Continued From page 8 R1 stated he managed his insulin independently, but the facility stored the insulin for him in the refrigerator and held onto the needles for the insulin pen. During an interview on May 31, 2023, registered nurse (RN)-C stated R1 independently set the dose on the prefilled insulin pen and injected his own insulin. RN-C stated the care plan, medication management plan, and individual abuse prevention plan did not address management of R1's insulin. During an interview on June 6, 2023, at 9:00 a.m. director of nursing (DON)-E stated she, RN-C, or licensed assisted living director (LALD)-A documented communication with pharmacy, communication with primary care providers, and medication set up to send with residents on leaves of absence. DON-E stated the practice at the facility was for R1 to check his own blood sugar and for the staff to look at the number and write it down in R1's logbook. The Medication Management Services policy (undated) indicated the registered nurse would develop an individualized medication management plan consistent with current practice standards with specific instructions relating to the administration of the medications. The policy indicated the registered nurse would reassess the resident's medication management services as needed and modify the individualized medication management plan. The policy indicated the facility would document communication with the prescriber, pharmacist, and resident, as well as document medication set ups. The Content of Resident's Medication Records policy (undated) indicated the resident's record	02310		

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02310	Continued From page 9 must contain documentation of when staff gave medications to the resident when the resident would be away from home during scheduled medication times. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	03000		

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03000	Continued From page 10 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) a medication error for one of one resident (R1) reviewed when an unlicensed staff person (ULP)-B gave R1 medications meant for another resident; as a result R1 was hospitalized. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35639	A. BUILDING: _____ B. WING _____	C 05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 11 The findings include: Review of R1's medical record indicated R1 lived in an assisted living with diagnoses including insulin dependent diabetes mellitus and traumatic brain injury. R1's Assessment document dated June 22, 2022, indicated R1 required full medication management including medication set-up. An Incident Report dated January 24, 2023, indicated ULP-B gave another residents medication to R1 when the other resident left her own pill pack on table. ULP-B administered the medications from the pill pack to R1. R1 was sent to emergency department for evaluation. A hospital record dated January 24, 2023, indicated R1 had accidental ingestion of multiple unknown medications after being given medications in error. The case was discussed with poison control and R1 was admitted for observation of blood sugar and blood pressure for two days then returned to the facility. During interview on May 30, 2023, at 10:49 a.m., ULP-B stated she gave R1 another residents medications in error. ULP-B stated she immediately called director of nursing (DON)-C to report a medication error. DON-C directed ULP-B to check R1's vital signs which were in normal range. ULP-B stated DON-C was on her way to the facility to assess R1 in person, however R1's friend contacted 911 before DON-C arrived. ULP-B stated the paramedics transported R1 to the hospital for evaluation. ULP-B did not make a report to MAARC. During interview on May 31, 2023, at 12:00 p.m.,	03000		

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03000	Continued From page 12 licensee assisted living director (LALD)-A stated the licensee should have filed a report to MAARC when R1 was administered another residents' medications in error. Reporting Maltreatment of Vulnerable Adult Policy (undated) indicated that all or suspected cases of adult maltreatment are reported. Emergency Procedure/911 Calls Policy (undated) indicated the registered nurse would contact MAARC immediately (no later than 24 hours) if the incident is reportable under the Vulnerable Adult Act TIME PERIOD FOR CORRECTION: Seven (7) Days	03000		