Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369879705M
Compliance #: HL369877608C

Date Concluded: February 6, 2024

Name, Address, and County of Licensee Investigated:
24-Seven Home Care
10774 Regent Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN, Special Investigator

Finding: Allegation 1- Substantiated, facility and individual responsibility
Allegation 2-Inconclusive

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):
Allegation 1-The alleged perpetrator (AP)1, a facility staff, abused a resident when AP1 punched the resident, knocking him to the floor.

Allegation 2- The alleged perpetrator (AP)2, a different facility staff, abused the resident when AP2 hit the resident's arm and slapped the resident across the face with an open hand while they were on an outing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated in allegation 1. The facility and AP1 were responsible for the maltreatment. Surveillance video showed AP1 grab the resident's arm, struggle with the resident, and the resident punched AP1 and walked away. As the resident was walking away, AP1 charged at the resident from behind and struck the resident and knocked him to the floor. The resident had redness on his left cheek and a cut inside his

mouth (due to braces) from AP1's punch. The resident required twice weekly therapy sessions after the incident. The facility failed to ensure staff were trained and used appropriate behavioral interventions when the resident was verbally and physically aggressive.

Allegation 2 was inconclusive. The resident reported AP2 slapped him, AP2 acknowledged the incident, but denied she touched the resident. There was no witness or documentation to prove or disprove the allegation.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's family member and law enforcement. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator viewed law enforcement body worn camera video which included facility surveillance video from the incident.

The resident lived in an assisted living facility. The resident's diagnoses included fetal alcohol syndrome, bipolar disorder, post-traumatic stress disorder, and impulsivity. The resident's service plan included reminders for bathing, dressing, eating, hygiene, and assistance with medication management, housekeeping, and laundry. The resident's care plan indicated the resident behaviors included elopement, difficulty weighing advice, disobeying, not listening to redirection, verbal aggression, and physical aggression. The care plan provided staff interventions that included redirecting the resident from entering restricted areas, securing exits, redirecting behaviors, encouraging verbalization of anger, confronting disobedience, encouraging use of coping skills, refraining from arguing, conveying a calm attitude, and increasing staffing to show strength.

A law enforcement report indicated officers responded to a call of a fight between staff and a resident at the facility. The report indicated an officer interviewed AP1, who stated he pushed the resident and knocked him to the ground after the resident hit AP1. The report indicated the officer interviewed two residents who witnessed the altercation. One resident witness stated AP1 punched the resident. The other resident witness stated both AP1 and the resident were punching.

The investigator viewed surveillance video of the incident between AP1 and the resident. In the video (there was no audio) the resident appeared to be arguing with AP1 in the living room while pointing to a phone the resident carried. The resident walked from the living room toward two residents standing in the entryway of the facility. AP1 got up from the chair in the living room, walked over to the resident, and grabbed the resident's arm holding the phone. The resident and AP1 struggled, and AP1 took the phone from the resident. The resident swung at AP1, who blocked it with his hand. The resident then punched AP1 with his left fist on AP1's right cheek. AP1 took a few steps back. The resident turned away and walked in between the two peers in the entryway. AP1 charged at the resident and struck him, with both hands, on his

left cheek and head, knocking the resident to the floor. AP1 stepped around the resident and assisted another resident who was knocked down during the incident.

During an interview, the nurse stated the facility was aware of the resident's behaviors before admission, but the nurse felt she did not get the full story. The nurse stated the resident did not follow the rules and he was a problem. The nurse stated she reviewed the video of the incident. The nurse stated the resident attacked AP1, who retaliated. The nurse stated she thought AP1 was remorseful. The nurse stated after the incident she had AP1 review an article on de-escalation and moved him to work at another of their facilities.

During investigative interviews, multiple staff members stated the resident was manipulative, lied, abused the system, knew what he could get away with, and bullied staff. Staff members stated the plan for the resident was to tell him to go to his room to calm down or they would call the nurse. None of the staff identified interventions from the care plan/behavior plan, although one staff stated she remembered there was a book somewhere.

During an interview, a family member stated she had concerns of the facility's ability to provide appropriate care for the resident within a few months of admission, so they began looking for different placement. The family member stated she did not think the facility trained staff for mental health issues and staff blamed the resident for his behaviors. The family member stated she spoke with the resident right after the incident, and he was very upset. The family member stated she called 911. The resident's team moved the resident to crisis housing.

During an interview AP1 stated the incident occurred because the resident would not give back the phone. AP1 stated he tried to block the resident from hitting him, and knew he was not supposed to hit a resident. AP1 denied punching the resident, and stated "If I punched him, he would have a bruise on his face for a week."

During an interview, the resident stated AP1 was angry with him before the incident because the resident confronted AP1 regarding lying about the nurse calling. The resident stated AP1 grabbed his arm and took the phone from him. The resident stated AP1 punched him in the face and knocked him down and that two housemates witnessed it. The resident stated he wanted to call 911, but AP1 refused to give him the phone. The resident stated he used his computer to contact his family member, who called 911. The resident stated the punch caused a cut inside his mouth from his braces. The resident stated he was very upset and had to increase therapy sessions to twice a week after the incident.

During an interview, AP2 stated the second allegation occurred in a facility vehicle. The resident, three peers, a staff member, and AP2, were in the vehicle going to the YMCA. The staff, who was driving, stopped at a convenience store, and got out of the vehicle. The resident had a basketball and was trying to spin it. AP2, who sat in the second row of seats with the resident, stated she told him to stop, as she did not want the ball to hit her. AP2 stated the resident would not stop spinning the ball, and it hit her. AP2 stated she became angry and

smacked the ball to the front seat. AP2 stated she and the resident argued about who was going to file a report on the other. AP2 stated the resident apologized several times. AP2 stated she did not document the incident and denied hitting the resident.

During an interview, a family member stated the resident told her that AP2 slapped his face after the ball hit her. The family member stated the facility did not investigate the incident and felt they did not care.

The facility had no documentation of the second incident or which residents were in the van. The facility nurse refused to allow resident interviews without guardian approval and staff took the residents from the facility for an activity during the three hours the investigator was onsite.

In conclusion, the Minnesota Department of Health determined abuse was substantiated in the first incident and inconclusive in the second incident.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
The facility moved AP1 to work at another of its houses until the resident moved out.
The facility required AP1 and all staff to read an article on de-escalation methods.

No action taken regarding the second incident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	**10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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, this correction order is 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: #HL369877608C/#HL369879705M On January 23, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL369877608C/#HL369879705M, tag identification 0730,2310, and 2360.	0 000		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	**10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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
0 730	Continued From page 1 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 730	Continued From page 2 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the medical record contained required documentation for one of one resident (R1) reviewed for maltreatment. The licensee had no progress notes detailing changes in the resident's behaviors, incidents involving the resident, or documentation of services provided as identified in the service plan. 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). Findings included: R1 was admitted to the assisted living on June 15, 2023, due to diagnoses including fetal alcohol syndrome, bipolar disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder, and impulsivity. R1's nursing assessments dated June 17, June 29, September 27, and December 26, 2023, indicated R1's behaviors included abuse toward others, wandering, impulsivity, mania, and property destruction. The assessments indicated staff were directed to document episodes of abusive behaviors, monitor and document episodes of wandering behaviors, document	0 730	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	**10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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
0 730	Continued From page 3 frequency of impulsive behaviors, document manic episodes, and document frequency of property destruction. During an interview on January 23, 2024, at 10:45 a.m. assisted living director/registered nurse (ALD/RN)-A stated most of the facility staff used English as a second language and had poor writing skills, so the facility did not have documentation detailing residents' day to day activities, services, or behaviors. The Minnesota Department of Health (MDH) investigator requested R1's progress notes, incident reports, and documentation of services completed, but did not receive these documents from the licensee. The MDH investigator requested but did not receive policies for service plans and behavioral interventions. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 730		
02310 SS=I	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 ensure staff implemented appropriate behavior interventions for one of one	02310	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
02310	Continued From page 4 resident (R1) reviewed for maltreatment. Multiple unlicensed personnel interviewed indicated lack of knowledge of behavioral interventions in the care plan. Harm occurred when unlicensed personnel (ULP)-B punched R1 during a behavioral incident. R1 received a cut inside his mouth and required increased psychotherapy (twice weekly for two months). 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 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). Findings include: R1 admitted to the facility on June 15, 2023, due to diagnoses that included fetal alcohol syndrome, bipolar disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder, and impulsivity. R1's Master Care Plan document (undated) indicated staff interventions for "abusive behavior" included implementation of close monitoring, encouragement to verbalize anger, redirection of abusive behaviors, addressing issues, distracting R1, spending one to one time listening to R1 vent. R1's Master Care Plan document (undated) indicated staff interventions for "disobeying/not listening to redirection" included confronting the behaviors, providing attention, helping R1 identify the reason for disobedience, encouraging	02310	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
02310	Continued From page 5 discussion of angry feeling, encouraging use of positive coping skills, and refraining from arguing with R1. R1's Master Care Plan document (undated) indicated staff interventions for physical aggression included removing dangerous objects, assisting R1 to identify the object of his anger, exploring alternative ways to handle frustration with R1, remaining calm, and administering as needed (PRN) medications. R1's progress notes, services completed documentation, and incident reports were requested but not provided by the licensee. A police report dated November 30, 2023, at 9:30 p.m. indicated an officer responded to a call for an assault at a group home, where staff allegedly punched a resident in the face. The report indicated an officer interviewed staff (unlicensed personnel (ULP)-B and ULP-H) who were in the facility at the time. The report indicated management (assisted living director/registered nurse (ALD/RN)-A) was unwilling to respond to the facility due to the frequency of such incidents. The report indicated two residents of the facility witnessed the altercation and both told police ULP-B punched R1. During an interview on January 23, 2024, at 11:28 a.m. assisted living director/registered nurse (ALD/RN)-A stated R1 disobeyed the rules for showering and using the phone. ALD/RN-A stated R1 was verbally abusive and physically aggressive to staff. ALD/RN-A stated there was an incident between R1 and unlicensed personnel (ULP)-B that she saw on facility surveillance video. (ALD/RN-A stated the video no longer existed, so could not provide it for the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	**10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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
02310	Continued From page 6 investigation.) ALD/RN -A stated R1 wanted to hold the phone but did not sign up for it per the house rules, so ULP-B took it from him. ALD/RN-A stated R1 punched ULP-B and ULP-B punched R1 in retaliation. During an interview on January 23, 2024, at 2:38 p.m. ULP-B stated R1 always had behaviors like swearing, wanting different food, threatening to hit staff. ULP-B stated R1 argued with him one evening about a phone call and took the house phone. ULP-B stated he told R1 he could not have the phone until he calmed down. ULP-B stated R1 was verbally abusive to him, calling him names. ULP-B stated he did not hit R1, just blocked a punch. On January 24, 2024, at 10:00 a.m. the Minnesota Department of Health (MDH) investigator received/reviewed a police officer's body worn camera video footage, which included surveillance video (without audio) from the facility of the night of the above incident. The video showed ULP-B and R1 arguing with R1 pointing to a phone. The video showed ULP-B got up, grabbed R1's left arm, struggled with R1, and took the phone. In the video R1 then punched ULP-B (who tried to block it). The video showed R1 turned and walked away. As R1 was walking away, ULP-B charged at R1, striking him from behind, with both hands. ULP-B hit R1 on the left side of his cheek and back of R1's head, knocking him to the ground. During an interview on January 25, 2024, at 11:33 a.m., ULP-D stated staff received training on how to work with R1 when he was agitated. ULP-D stated the information was in a book somewhere. ULP-D stated she would tell R1 to be nice and then she would call assisted living	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	**10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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
02310	Continued From page 7 director/registered nurse (ALD/RN)-A to complain about R1. ULP-D stated R1 had behaviors such as name calling, and ULP-D stated she would tell other staff to deal with R1, but many quit. During an interview on January 25, 2024, at 12:46 p.m. ULP-E stated R1 was verbally abusive, lied, manipulated, bullied staff, and bullied residents. ULP-E stated she would redirect R1, telling him to go to his room, calm down, and then come back to talk about his behavior. ULP-E stated R1's goal was to stay out of trouble and mind his own business. ULP-D stated she would tell R1 they were going to call the nurse or manager. ULP-D stated R1 would not follow house rules and chose his behaviors. During an interview on January 25, 2024, at 2:28 p.m. clinical behavior consultant (CBC)-F stated she provided staff training on fetal alcohol syndrome and trauma informed care one time at the facility. CBC-F stated she made weekly calls and emails to ALD/RN to try to set up additional training, but ALD/RN-A was not receptive to additional training. CBC-F stated ALD/RN-A did not share how or if they used her information/training or if they incorporated it into a plan of care for R1. During an interview on January 25, 2024, at 4:30 p.m. ULP-G stated R1 was rude, swore, refused to comply, and slammed his door. ULP-G stated the plan was to give R1 a medication to cool down and then he could be around people. ULP-G stated she had an incident with R1 when he hit her with a basketball, and she got mad. ULP-G stated after that incident she told R1 she was not there to talk with him about things. During an interview on January 29, 2024, at 2:32	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
02310	Continued From page 8 p.m. ULP-H stated R1 was rude, belligerent, and wanted to be in control. ULP-H stated the facility was very structured and R1 did not like that. ULP-H stated all residents were to wake up at 7:00 a.m., make their bed, eat breakfast, and then do chores. ULP-H stated R1 had difficulty understanding the staff due to language and cultural barriers. ULP-H stated the facility trained staff to direct R1 to his room to calm down or call ALD/RN to calm him down. Documentation of staff orientation to R1 and R1's service plan was requested but not received. Documentation of services completed, progress notes, and incidents involving R1 were requested but not received. A policy for implementation of service plans/behavior plans was requested, but not received. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
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(s) reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	**10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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
02360	Continued From page 9 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		