Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370658905M
Compliance #: HL370656485C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:
Minn Care Home Health
7055 Perry Avenue North
Brooklyn Center, MN 55429
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: 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):
The alleged perpetrator (AP) sexually abused resident 1 and resident 2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Both resident 1 and resident 2 could not recall the date, time, or details of the alleged abuse. The AP failed to respond to a subpoena for an interview but denied the allegations to facility management during the internal investigation.

The investigator conducted interviews with facility staff members, including administrative staff, unlicensed staff and both residents. The investigator contacted a family member and external medical services providers. The investigation included review of both resident's medical records, the AP's personnel file, external medical records, staff schedules and training, facility policies, the facility internal investigation and law enforcement records. Also, the investigator

completed an onsite visit to the facility and observed staff preparing and serving a meal, giving medications, and assisting residents.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included generalized anxiety disorder, seizure disorder and attention deficit hyperactivity disorder. Resident 1's service plan included assistance with behavior management, meal preparation, medication administration and hygiene. Resident 1's assessment indicated he was alert, oriented and independent with walking.

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included mental retardation, attention deficit hyperactivity disorder, post-traumatic stress disorder and borderline personality disorder. Resident 2's service plan included assistance with behavior management, meal preparation, and medication administration. Resident 2's assessment indicated she was alert, oriented and independent with activities of daily living.

Resident 1 reported to the facility staff the AP had touched him inappropriately. Resident 1 could not recall the date but stated it may have happened three weeks prior when the AP was doing routine laundry service for him. Additionally, resident 1 reported resident 2 told him the AP had inappropriate sexual interactions with her as well.

A facility incident report indicated resident 2 reported to administrative staff the AP had twice raped her, but could not recall the dates, times or details of the incidents.

Law enforcement records indicated law enforcement attempted three times to follow up with resident 2 on the sexual abuse allegation. Resident 2 did not answer her phone or return calls to them.

During an interview, administrative staff stated there had been no concerns or disciplines with the AP's employment. Administrative staff stated the AP denied the allegations and resigned while suspended pending the investigation. Administrative staff stated resident 1 told him he blamed the AP for ruining his relationship with resident 2, so he was going to deal with the AP for doing that.

During an interview, resident 1 stated the AP came in his room one night telling him he should change his clothes and began groping his genitals with his hand on the outside of his clothes. Resident 1 stated he told the AP to stop, and the AP repeatedly asked resident 1 if he liked it. Resident 1 stated he told the AP no, and the AP stopped after he told the AP he would report the AP to management. Regarding his medication, resident 1 stated he did not have his seizure medication for a couple weeks due to a refill issue. Resident 1 stated the occurrence of his seizures increased during that time.

During an interview, resident 2 stated she was half asleep in her room when the AP entered her room, took his clothes off, got on top of her, began to kiss her and have sexual intercourse with

her. Resident 2 stated she told him to stop and when he did not, she laid there in fear until he stopped. Resident 2 stated the AP was always giving her gifts, telling her he loves her and inviting her to his pool at his personal residence. Resident 2 stated there was only one sexual incident with the AP.

During an interview, a family member stated resident 1 reported he had issues with one staff person who always seemed to be picking on him and accusing him of messing something up when he had not. The family member stated resident 1 said he felt safe in the facility.

The investigator was unable to the reach the AP for an interview.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive for R1.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive for R2.

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.

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:
(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:
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes, both.
Family/Responsible Party interviewed: Yes, for resident 1. Resident 2 had no family contacts.
Alleged Perpetrator interviewed: No, did not respond to request for interview.

Action taken by facility:

The facility reported the incidents to the Minnesota Adult Abuse Reporting system and the AP was no longer employed at the facility.

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

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
	37065	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY 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: #HL370656485C/#HL370658905M On November 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 five residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL370656485C/#HL370658905M, tag identification 1730.	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.	
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 1 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 2 medication management. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure medication refills were ordered on a timely basis, as required for one of one residents (R1) reviewed. R1 abruptly missed 12 doses of his antiseizure medication that has a high risk of serious health problems if stopped. R1 experienced an increase in his seizures. 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: A Food and Drug Administration document released a saety announcement on April 25, 2018, warning of serious immune system reaction with seizure and mental health use of lamotrigine (anti-seizure medication). The document directed, "Do not stop taking lamotrigine without talking to your health care professional first as doing so can cause serious problems." The document indicated stopping lamotrigine without first talking to a prescriber can lead to uncontrolled seizures, or new or worsening mental health problems. R1's diagnosis included general anxiety disorder, seizure disorder and attention deficit hyperactivity disorder. R1's service plan dated September 1, 2023, indicated R1 received assistance with	01730		

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01730	Continued From page 3 behavior management, medication administration, and hygiene. R1's medication administration record (MAR) dated September 2023, indicated R1 missed 12 doses of his ordered lamotrigine due to it not being available for administration. The MAR also indicated 9 doses of sertraline (anti-depressant) were not given due to not being available. During an interview on December 4, 2023, at 12:30 p.m., licensed assisted living director (LALD)-C stated when medications are running low, either himself, another facility owner, or the facility nurse will call in to the pharmacy a ninety day supply refill. LALD-C denied running out of medication. Later in the same interview, LALD-C stated there was a time when R1's seizure medication was not available. LALD-C stated the pharmacy was closed on fridays, so the medication was not available until monday. LALD-C stated they had been calling in the refill and the provider was supposed to send it in, but did not. LALD-C stated R1 did not have his medication for a couple of days and did not have any seizures. During an interview on December 5, 2023, at 9:12 a.m., family member (FM)-D stated there were incidents involving his medication. FM-D stated the licensee ran out R1's seizure medication and did not refill it until another family member confronted the licensee about it. During an interview on December 6, 2023, at 3:20 p.m., R1 stated there was a time he did not have his seizure medication for a couple of weeks, and his seizures increased and got worse. R1 stated it took a while to get his seizures under control again once he got back on the medication.	01730		

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01730	Continued From page 4 Licensee-provided policy titled "Medication and Supplies Reordeirng Policy" date January 1, 2020, indicated staff will assist clients to make sure medications and supplies are ordered and available as needed. The policy indicated if a client needs medications, staff will contact the pharmacy by calling the refill prescription or request. TIME PERIOD FOR CORRECTION: 7 days	01730		