DEPARTMENT OF HUMAN SERVICES

December 4, 2024

Fatou Jallow, Authorized Agent
Empathy Home Care
4600 Oak Grove Parkway N
Brooklyn Park, Minnesota 55443

License Number: 1119230 (245D – HCBS)
Investigation Report Number: 202405348

CORRECTION ORDER

Dear Fatou Jallow:

On September 9-11, 2024, a licensing investigation of Empathy Home Care, located at 4600 Oak Grove Parkway North, Brooklyn Park, Minnesota, was conducted to determine compliance with state and federal laws and rules governing the provision of home and community-based services to persons with disabilities and age 65 and older under Minnesota Statutes, Chapter 245D. As a result of this licensing review a Correction Order is being issued.

A. Reason for Correction Order

Pursuant to Minnesota Statutes, section 245A.06, if the Commissioner of the Department of Human Services (DHS) finds that the license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the Commissioner may issue a Correction Order to the license holder.

The following violation(s) of state or federal laws and rules were determined as a result of the licensing review. Corrective action for each violation is required by Minnesota Statutes, section 245A.06 and is hereby ordered by the Commissioner of Human Services.

1. Citation: Minnesota Statutes, section 245A.65, subdivision 1.

Violation: For one of three persons whose records were reviewed (P1), the license holder did not provide an orientation to the internal to the internal and external reporting procedures of alleged or suspected maltreatment of vulnerable adults as required.

The license holder failed to provide P1 an orientation to the internal and external reporting procedures of alleged or suspected maltreatment of vulnerable adults within 24 hours of admission. P1's services were initiated on April 1, 2024.

The license holder documented that the orientation was provided to P1 on April 26, 2024.

Corrective Action Ordered: On an ongoing basis, you must maintain compliance as required in this subdivision.

2. Citation: Minnesota Statutes, 245D.04, subdivision 3.

Violation: For two persons whose records were reviewed (P1 and P3), the license holder did not meet the requirements for a rights restriction.

a. The license holder failed to obtain a signed and dated approval from P1's legal representative for a rights restriction to be implemented for P1.

b. The license holder maintained documentation in the support plan addendum for a restriction of P3's rights. At the time of the licensing review, there was no evidence that the license holder had documented objective measures set as conditions for ending the restriction.

Corrective Action Ordered: Immediately, upon receipt of this order, you must:

- obtain the signature and date of approval from P1's legal guardian for P1's rights restriction; or discontinue the restriction; and
- document the objective measures set as conditions for ending P3's rights restriction in P3's support plan addendum.

On an ongoing basis, you must maintain compliance as required in this subdivision.

3. Citation: Minnesota Statutes, section 245D.05, subdivision 2, paragraph (c).

Violation: For two persons whose records were reviewed (P1 and P2), the license holder did not maintain the medication administration record as required.

The license holder failed to maintain the following information in P2's medication administration record (MAR) and ensure that this information was readily available to all staff administering medication:

- information on any risks or other side effects that are reasonable to expect, and any contraindications to its use;
- possible consequences if the medication or treatment is not taken or administered as directed;
- instruction on when and to whom to report the following:
  - if a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and

- the occurrence of possible adverse reactions to the medication or treatment.

Corrective Action Ordered: Within 30 days of receipt of this order, you must document the above mentioned information in P1's and P2's medication administration records. On an ongoing basis, you must maintain compliance as required in this subdivision.

4. Citation: Minnesota Statutes, section 245D.05, subdivision 4.

Violation: For two persons whose records were reviewed (P1 and P2), the license holder did not meet the requirements for reporting medication administration and treatment issues as required.

a. From May 2024 until July 2024, P1 refused his/her medications 165 times. The license holder failed to report each occurrence P1 refused to take his/her medications to P1's case manager.

b. From May 2024 until July 2024, P2 refused his/her medications 78 times. The license holder failed to report each occurrence P2 refused to take his/her medications to P2's case manager.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- review P1's and P2's medication administration records from January 2024 to current to identify medication errors, including medication refusals;
- based on the review of the medication administration records, report all occurrences of P1's and P2's refusals to take medications as prescribed to P1's case manager and P2's case manager; and
- maintain documentation of these reports to in P1's and P2's service recipient records.

On an ongoing basis, you must maintain compliance as required in this subdivision.

5. Citation: Minnesota Statutes, section 245D.051, subdivision 1.

Violation: For one person whose record was reviewed (P1), the license holder did not meet the requirements for psychotropic medication use and monitoring.

The license holder was assigned the responsibility for administering medications to P1. P1 was prescribed psychotropic medications. The license holder was responsible to collect and report on medication and symptom data. The license holder failed to:

- maintain documentation methods the license holder will use to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medication if required by the provider; and

- provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

Corrective Action Ordered: Within 30 days of receipt of this order, you must document the above mentioned information in P1's support plan addendum. In addition, you must provide the above mentioned monitoring data to P1's expanded support team. On an ongoing basis, you must maintain compliance as required in this subdivision.

6. Citation: Minnesota Statutes, section 245D.07, subdivision 1a.

Violation: For one person whose record was reviewed (P1), the license holder did not provide services in response to P1's identified needs, interests, preferences and desired outcomes as specified in the support plan addendum as required.

The license holder established the following outcomes for P1:

- P1 will maintain a stable mental and physical health for the next 12 months" and
- P1 will work with staff to maintain a healthy and clean living environment for the next 12 months."

The license holder documented in P1's support plan addendum dated April 2, 2024, that P1 would like to become part of a church community, and that the license holder would assist P1 with finding opportunities to obtain this outcome. The license holder failed to establish outcomes that P1 desires.

Corrective Action Ordered: Within 30 days of receipt of this order, you must:

- discuss with P1, P1's legal representative, and case manager outcomes P1 may desire and document the discussion in P1's service recipient record; and
- identify service outcomes P1 desires. Document P1's service outcomes and supports and methods in P1's service recipient record as ordered in citation number 9.

On an ongoing basis, you must maintain compliance as required in this subdivision.

7. Citation: Minnesota Statutes, section 245D.071, subdivision 3.

Violation: For two persons whose records were reviewed (P1 and P3), the license holder did not meet service planning requirements for intensive support services as required.

For P1 and P3, although the license holder did hold a meeting within 45 days of service initiation as required, the license holder failed to:

- have a discussion of how technology might be used to meet the person's desired outcomes;
- summarize this conversation and include it in P1's support plan addendum; and
- include a statement in the summary regarding any decision that is made regarding the use of technology and a description of any further research that

needs to be completed before a decision regarding the use of technology can be made.

Corrective Action Ordered: Within 30 days of receipt of this order, you must complete the following for P1 and P3:

- discuss with the person, their case manager, their legal representative (as applicable), and members of the support team about how technology might be used to meet the person's desired outcomes;
- include a summary of this discussion in support plan addendum; and
- include a statement in the summary regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made in the support plan or support plan addendum.

On an ongoing basis, you must maintain compliance as required in this subdivision.

8. Citation: Minnesota Statutes, section 245D.071, subdivision 4.

Violation: For three persons whose records were reviewed (P1, P2 and P3), the license holder did not document the service outcomes and supports as required.

a. Although the license holder had outcomes documented for P1 and P2, the license holder failed to document the following supports and methods to accomplish outcomes:
   - the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:
     - any changes or modifications to the physical and social environments necessary when the service supports are provided;
     - any equipment and materials required; and
     - techniques that are consistent with the person's communication mode and learning style;
   - the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;
   - the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and
   - the names of the staff or position responsible for implementing the supports and methods.

b. P3's 45 day planning meeting occurred on May 13, 2024. The license holder failed to develop a service plan that documents the service outcomes and supports within ten working days of the 45 day planning meeting. The license holder developed P3's service outcomes and supports on August 22, 2024.

Corrective Action Ordered: Within 30 days of receipt of this order, you must:

- develop a service plan for P1 and P2 that documents the service outcomes and supports that includes the following:
    - the methods or actions that will be used to support P1 and P2 and to accomplish the service outcomes, including information about:
        - any changes or modifications to the physical and social environments necessary when the service supports are provided;
        - any equipment and materials required; and
        - techniques that are consistent with the person's communication mode and learning style;
    - the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected; and
    - the names of the staff or position responsible for implementing the supports and methods.

On an ongoing basis, you must maintain compliance as required in this subdivision.

9. Citation: Minnesota Statutes, 245D.10, subdivision 4.

Violation: For two persons whose records were reviewed (P1 and P2), the license holder did not provide written or electronic copies of policies and procedures as required.

a. P1's services were initiated on April 1, 2024. The license holder failed to inform P1 and P1's legal representative of the following policies and procedures that affect a person's rights and provide copies of those policies and procedures, within five working days of service initiation:
    - grievance policy;
    - service suspension policy;
    - service termination policy;
    - emergency use of manual restraints policy; and
    - data privacy.

    The license holder informed and provided copies of the policies to P1 and P1's legal representative on April 26, 2024.

b. The license holder failed to inform P2's case manager of the policies and procedures affecting P2's rights under section 245D.04, and provide copies of the following policies and procedures, within five working days of service initiation:
    - grievance policy;
    - service suspension policy;
    - service termination policy;
    - emergency use of manual restraints policy; and
    - data privacy.

Corrective Action Ordered: Within 30 days of receipt of this order, you must provide P2's case manager with written or electronic copies of the above-mentioned policies and procedures. On an ongoing basis, you must maintain compliance as required in this subdivision.

10. Citation: Minnesota Statutes, section 245D.095, subdivision 3, paragraph (b).

Violation: For one person whose record was reviewed (P1), the license holder did not maintain service recipient records as required.

The license holder failed to document P1's medication allergy on his/her admission form.

Corrective Action Ordered: Immediately upon receipt of this order, you must document all service recipient allergies in their admission forms, and throughout the addendum. On an ongoing basis, you must maintain compliance as required in this subdivision.

11. Citation: Minnesota Statutes, section 245D.095, subdivision 3.

Violation: For one person whose record was reviewed (P1), the license holder did not provide progress reports as required.

The license holder assigned themselves the responsibility of quarterly progress reports for P1. The license holder failed to provide progress reports as assigned in the support plan addendum.

Corrective Action Ordered: On an ongoing basis, you must maintain compliance as required in this subdivision.

12. Citation: Minnesota Rules, 9544.0110.

Violation: For one person whose record was reviewed (P1) the license holder did not report behavioral incidents as required.

The license holder maintained documentation that 911 was summoned for P1 as the result of mental health crises occurring on the following dates:

- June 19, 2024
- July 11, 2024
- August 5, 2024
- August 26, 2024; and
- August 28, 2024

The license holder failed to report the above incidents that involved P1 to the commissioner using the behavior intervention report form (BIRF) required by the commissioner.

Corrective Action Ordered: Within 15 days of receipt of this order, you must report the above mentioned incidents using the BIRF form required by the commissioner. You must maintain the BIRF form in P1's record. On an ongoing basis, you must maintain compliance as required in this subdivision.

13. Citation: Minnesota Statutes, section 245D.06, subdivision 1, paragraph (a).

Violation: For one person whose record was reviewed (P1), the license holder did not respond to incidents as required.

The license holder failed to report incidents to P1's legal representative or designated emergency contact and case manager within 24 hours.

Additionally, the license holder failed to follow the program's "Incident Response, Reporting and Review Policy" when the license holder failed to follow reporting procedures and conduct reviews of the incidents involving P1.

Corrective Action Ordered: Within 30 days of receipt of this order, you must:

- report the incidents documented in citation 12 to P1's legal representative or designated emergency contact and case manager; and
- maintain documentation of these notifications in P1's service recipient record;
- complete written reports for each incident documented in citation 12 involving P1. The written reports must include:
    - the name of the person or persons involved in the incident;
    - the date, time, and location of the incident;
    - a description of the incident;
    - a description of the response to the incident and whether a person's support plan addendum or program policies and procedures were implemented as applicable;
    - the name of the staff person or persons who responded to the incident;
- complete a review of the incidents involving P1. The review must:
    - ensure that the written report for each incident provides a written summary of the incident;
    - identify trends or patterns, if any, an determine if corrective action is needed; and
- if it is determined corrective action is needed, take corrective action within the time period specified in your program's Incident Response, Reporting and Review Policy. You must document any corrective action that must be completed, including the date it was completed.

On an ongoing basis, you must maintain compliance as required in this subdivision.

RECOMMENDATION

The following recommendations are not requirements of Minnesota Rules or laws governing your services or facility. These recommendations are provided to call your attention to areas where your facility is in minimum compliance with the requirements of rules or laws, but it would be advisable to strengthen your efforts in these areas.

Failure to follow these recommendations will not result in a fine or action against your license at this time. However, should failure to follow recommendations result in a violation of rules or laws at a future date, you will be cited for noncompliance and may be subject to fines or action against your license.

Area of Minimal Compliance: Minnesota Statutes, section 245D.05, subdivision 1, paragraph (b).

The license holder maintained a protocol in P1's record with documentation of the description of the procedures the license holder would follow in order to safely administer P1's as needed (PRN) medication for anxiety. However, the procedures were documented to begin when P1 is at baseline, including the administration of the PRN medication when P1 was starting to experience symptoms of anxiety.

It is recommended that you discuss P1's mental health needs with P1's prescriber to develop a PRN protocol for when to administer P1's PRN anxiety medication that supports P1's mental health needs appropriately. It is recommended that you document the PRN protocol in P1's record and ensure all staff who provide direct support services to P1 are trained on the PRN protocol.

B. Right to Request Reconsideration

If you believe any of the citations are in error, you have the right to request that the Commissioner of Human Services reconsider the parts of the Correction Order that you believe to be in error. The request for reconsideration must be in writing and received by the Commissioner within 20 calendar days after receipt of this report. Your request for reconsideration must be sent to:

Commissioner, Department of Human Services
Office of Inspector General
Legal Counsel's Office
Attention: Licensing Legal Unit
PO Box 64953
St. Paul, MN 55164-0953

Please note that a request for reconsideration does not stay any provisions or requirements of the Correction Order. The Commissioner's disposition of a request for reconsideration is final and not subject to appeal under Minnesota Statutes, chapter 14.

If you have any questions regarding this Correction Order, please contact Kate Spenger at kate.spenger@state.mn.us or 651-431-5757 as soon as possible.

Kate Spenger, Human Services Licensor
Licensing Division
Office of Inspector General
651-431-5757