

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL215085983M  
**Compliance #:** HL215081262C

**Date Concluded:** December 4, 2023

**Name, Address, and County of Licensee**

**Investigated:**

Dr. Thomas Johnson HWS  
5155 Penn Avenue South  
Minneapolis, MN 55419  
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Peggy Boeck, RN  
Special Investigator  
Jessica Sellner, 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):**

It is alleged the facility neglected a resident when they refused to store and administer one of the resident's medications (methadone- a long-acting opioid medication used to reduce withdrawal symptoms in people addicted to narcotics and/ or pain relief) and failed to ensure he attended medication appointments.

It is also alleged an unknown Alleged Perpetrator (AP) abused the resident, when the resident woke with injuries of unknown origin including swollen, bruised, and bloodied face.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was inconclusive, due to conflicting information. The facility indicated the resident refused to go to the clinic to obtain his methadone, and the resident stated the facility did not arrange appropriate transportation for

him to go to the clinic, so he just quit going. The clinic staff indicated they spoke with the resident's team prior to admission, and the facility was aware of the possibility of weekly takeouts (an exception granted for the facility to securely obtain a weeks' worth of methadone). The facility indicated the resident's team discussed and agreed to daily dosing at the clinic. The resident stated no one talked to him about getting a week of methadone at a time instead of the resident traveling to the clinic 6 days a week.

The allegation of abuse is not substantiated. The resident could not offer a timeline of when the alleged incident occurred or witnesses to his injuries. The facility documentation did not include any incident with similarities to the allegation.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's case manager and primary counselor at the clinic. The investigation included review of medical records, facility documents, policies, and procedures related to assessments, staffing, medication administration, and maltreatment of vulnerable adults. The investigator observed staff/resident interactions and the facility medication administration system and narcotic storage.

The resident lived in an assisted living facility due to diagnoses that included osteomyelitis (bone infection) of right hip with resection (removal) of femoral head (top of thigh bone), post-traumatic stress disorder, substance abuse, and depression. The resident's medical records indicated he was wheelchair bound, due to inability to walk on his right leg. The resident's service plan indicated the resident received services from the facility that included medication assistance, medication set-up, positioning, and transfer assistance of two staff with a full mechanical lift.

The resident's nursing assessment identified that the resident required assistance with medication storage, ordering, set-up, and administration.

The resident's record contained a document signed two days after admission indicating the resident took responsibility for "obtaining, securing, maintaining, and self-administration of prescribed methadone."

Nursing progress notes indicated approximately three weeks after admission to the facility, the resident refused, on several days, to go to the clinic for his methadone. Facility records indicated the following week the resident told the nurse he was not continuing with the methadone clinic.

During an interview, the resident expressed concerns of staffing and indicated they often had only one staff, so were unable to transfer him out of bed to prepare for a clinic visit. The resident stated the facility "messed" with his transportation (changing times), making it difficult to get to the clinic, and when the rides stopped coming, the resident quit going to the clinic. The

resident stated the facility suspected him, and his visitors, of using drugs and had the police come to the facility but found nothing.

A review of the facility schedules indicated they scheduled a minimum of two staff on the day shift (7:00 a.m. to 7:30 p.m.), two staff on the night shift (7:00 p.m. to 7:30 a.m.), and for several months added extra staff assigned one to one for the resident.

During an interview, a counselor from the methadone clinic stated the clinic had extensive discussions with the facility regarding the resident's methadone prior to his admission to the facility. The counselor stated the clinic team discussed with the facility options for administration of methadone at the facility.

During investigative interviews, several staff members stated the resident often refused cares and had many verbal outbursts. Staff indicated they suspected the resident of using drugs.

In conclusion, neglect is inconclusive, and abuse is 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.

**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.

**"Not Substantiated" means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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:

- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224.

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;

**Vulnerable Adult interviewed:** Yes

**Family/Responsible Party interviewed:** No. Permission not obtained from the resident.

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:**

The facility discharged the resident.

**Action taken by the Minnesota Department of Health:**

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>21508</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/20/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DR THOMAS H JOHNSON HWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5515 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419</b>
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(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	<p><b>Initial Comments</b></p> <p>On November 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL215081262C/#HL215085983M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_