Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347718082M
Compliance #: HL347714321C

Date Concluded: May 7, 2025

Name, Address, and County of Licensee Investigated:
The Friendship Place LLC
152 King Street West
St. Paul, MN 55107
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Not Substantiated

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: The facility neglected the resident when he overdosed and required Narcan (reversal medication) and a call to 911 after he was found unresponsive.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility completed assessments and used interventions based on the resident's history of polysubstance abuse. Over a period of a week, facility caregivers responded to the resident's behaviors including overdose, removed needles and drugs from his room, and contacted a crisis line when the resident threatened staff with a knife.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during a recent visit to the facility.

The resident resided in an assisted living facility with diagnoses that included bipolar disorder, traumatic brain injury (TBI), attention deficit disorder and polysubstance abuse. The resident's service plan included assistance with medication management. The resident's assessment indicated he had impaired judgment and forgetfulness related to his TBI and needed reminders to attend daily Methadone clinic appointments.

A facility incident report indicated one night the resident did not respond when staff knocked on the door during a safety check. Staff found the resident unconscious in the bathtub. The staff gave the resident Narcan medication and called 911. The resident regained consciousness with the Narcan and was sent to the hospital for evaluation.

The progress notes indicated during that same week the resident was observed to be disoriented and stumbling, prompting another call to 911. Drug paraphernalia was found and removed from the resident's room. During the same week, the progress notes also indicated the resident suffered a mental health crisis and may have threatened staff so 911 was called again.

During an interview, a manager stated it was a difficult week for the resident after he became upset when over an event related to the holidays. The manager stated that after the incidents, room checks for drugs were put into place and other channels to release his anger were discussed with the resident.

During interview, a nurse stated that staff spoke with the resident about recognizing and avoiding triggers which might lead to a behavioral episode.

During interview, the resident stated at the time, he was overwhelmed with what was happening, specifically when an event regarding the holidays. He stated during that week he did not deal with his problems well and rather used a non-prescribed medication. Since then, a new anxiety medication and visits with his psychiatrist had helped him cope with difficulties.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: Additional mental health and behavioral training for staff.

Action taken by the Minnesota Department of Health: No further action at this time.

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
	34771	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FRIENDSHIP PLACE LLC	152 KING STREET WEST SAINT PAUL, MN 55107

(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 On April 15, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL347714321C/#HL347718082M. No correction orders are issued.	0 000		