Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355463543M
Compliance #: HL355465817C

Date Concluded: December 22, 2022

Name, Address, and County of Licensee Investigated:
Attentive Care
3524 Kyle Avenue North
Crystal MN, 55422
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility responsibility

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):
The facility neglected a resident when they failed to provide supervision that resulted in the resident's death from drug overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to the resident after they removed multiple street drugs from him. Facility staff found the resident deceased in his room, midafternoon, the following day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident's records, resident's death record, incident reports, employee records, and facility policies. The investigator toured the facility and observed interactions between residents and staff.

The resident resided in an assisted living facility. The resident's diagnoses included depression, anxiety, and hyperactivity disorder. The resident's service plan included assistance with medication management, safety checks, dressing, housekeeping, laundry, meal assistance, and behavior management. The resident's nursing assessment indicated the resident was alert and orientated to person, place, and time. The nursing assessment indicated the resident was independent with walking and left the facility independently. The assessment indicated the resident used street drugs and was at high risk for suicide related overdose.

The resident's master care plan indicated the resident used street drugs including heroin. The master care plan indicated the resident was at risk for overdose and suicide. The master care plan indicated the resident was at risk to abuse himself and others when he was angry. The care plan indicated the resident was angry when he did not have street drugs. The master care plan indicated staff should check the resident every fifteen minutes when he was in his room.

During an interview, unlicensed personnel (ULP #1) worked 7:00 p.m. to 7:00 a.m., and said the resident appeared agitated at the start of his shift. ULP #1 said the resident was "yelling" in his room. ULP #1 said he was working with another resident and unable to respond until approximately 8:00 p.m. ULP #1 said the manager was with him and they removed multiple street drugs, including a needle, from the resident's room. ULP #1 said the resident went outside to smoke, returned, and went to his room at approximately 8:30 p.m. ULP #1 said he did not see the resident later that evening or throughout the night. ULP #1 said he went into the hallway and heard snoring noises about 2:00 a.m. ULP #1 said he did not open the resident's door. ULP #1 said there were no other interventions put in place that evening for monitoring the resident. ULP #1 said he did not see the resident after approximately 8:30 p.m. ULP #1 said he left the next morning at 7:00 am.

During an interview, unlicensed personnel (ULP #2) said he started work at 7:00 a.m. the next morning. ULP #2 said ULP #1 told him about the incident from the night before and he was aware multiple street drugs were removed from the resident. ULP #2 said he did not see the resident in the morning or afternoon. ULP #2 said he did not open the resident's door that morning or afternoon. ULP #2 said a facility nurse arrived at approximately 2:00 p.m. ULP #2 said the nurse had to get a key to unlock the resident's door. ULP #2 said once the nurse opened the door, he saw the resident lying on the floor. ULP #2 said he called 911. ULP #2 said he did not see the resident between 7:00 a.m. and 2:00 p.m.

During an interview, a facility nurse said the manager informed her she removed street drugs from the resident's room. The facility nurse said the manager notified her that evening shortly after the incident. The facility nurse said she received pictures of the drugs, including a needle. The facility nurse said ULP #1 informed her drugs were in the resident's hands and room. The facility nurse said the resident hid drugs in his crotch. The facility nurse said because the resident had a history of abusing street drugs, she went to the facility midafternoon the following day. The facility nurse said she went to the resident's room and knocked, but there

was no response. The facility nurse said the resident's door was locked. The facility nurse said she took her key, unlocked the door, and saw the resident lying face down on the floor. The facility nurse said the resident was not breathing and did not have a pulse. The facility nurse said she started cardiopulmonary resuscitation (CPR), but the resident was deceased.

The resident's medication administration record indicated the resident refused his midnight medication. The medication administration record indicated the resident refused all his morning medication. The medication administration record indicated the reason for the resident's refusal was, "…he is ignoring me".

The resident's death record indicated cause of death was drug overdose.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

"Substantiated" means:
A preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility contacted law enforcement.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Crystal City Attorney
Crystal Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35546	A. BUILDING: _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) 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: **Revised** #HL355465817C/#HL355463543M On November 16, 2022, 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 three residents receiving services under the provider's Assisted Living license. On November 21, 2022, the immediacy of tag 470 was removed. However non-compliance remains at a scope and level of I. The following non-immediate correction orders are issued for #HL355465817C/#HL355463543M, tag identification 470, 630, 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	

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0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for providing the health and safety needs of three of three residents (R1, R2, R3) reviewed. Therefore, staff did not provide R1, R2, R3 their required services during the day.	0 470		

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0 470	Continued From page 2 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). The findings include: On November 16, 2022, at 9:23 a.m., the surveyor arrived at facility unlicensed personal (ULP)-A opened front door. The environment was dark, and all the lights were off. There were pillows and blankets were on the couch. During observation on November 16, 2022, at approximately 9:30 a.m., all residents were in their rooms and all bedroom doors were closed. The investigator was unable to locate a posted staffing schedule. R1's diagnosis included paranoia and schizophrenia. R2's diagnosis included major depression. R3's diagnosis included autism, ADHD and intellectual disability. Incident report dated May 8, 2022, indicated R2 had an altercation with a resident and obtained a knife and taunted the other resident. The incident report indicated the resident was "explosive". Incident report dated August 9, 2022, indicated R2 had a physical and verbal altercation with	0 470		

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0 470	Continued From page 3 another resident. Incident report dated August 22, 2022, indicated R2 had a physical and verbal altercation with another resident. Incident report dated October 6, 2022, indicated R3 was physically aggressive to other residents and staff. The report indicated police intervened. During an interview with ULP-A on November 16, 2022, at 9:30a.m., ULP-A said all residents independently walked, but were unable to communicate needs accurately. ULP-A said R3 was non-verbal. During an interview with licensee owner on November 16, 2022, at 2:00p.m., owner (OW)-B confirmed staff should be awake for their shifts. During an interview with licensee owner on November 17, 2022, at 9:30 a.m., OW-B said she observed camera images and ULP-A was lying on the couch that morning. The owner failed to identify the time range for ULP-A on lying on the couch when asked. The licensee acknowledged ULP-A should have been providing care services. TIME PERIOD FOR CORRECTION: IMMEDIATE On November 21, 2022, at 11:25 a.m., the immediacy was removed. The licensee provided education to staff regarding working awake expectations. The licensee posted staff schedule in visible location. The licensee had a plan in place to review video surveillance. The licensee had meetings scheduled to follow up on staffing expectations. Tag 470 remains issued at a level I.	0 470		

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0 470	Continued From page 4 TIME PERIOD OF CORRECTION: Seven (7) Days	0 470		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of four residents (R2, R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 630		

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0 630	Continued From page 5 The findings include: R2 admitted to the licensee on July 7, 2021. R2's diagnoses included paranoia and schizophrenia. R2's service agreement dated August 1, 2021, indicated R2 required assistance with behavior management, grooming, housekeeping, medication, safety check, and meals. R2's master care plan dated August 2, 2022, indicated R2 was at risk to abuse themselves, but failed to identify R2's risk for abuse from others. The care plan identified R2 had behaviors of public disrobing. The care plan indicated R2 was socially inappropriate. R2's individual abuse prevention plan (IAPP) dated August 2, 2022, indicated R2 was at risk for abuse themself, but failed to identify her risk to be abused by others. The assessment indicated R2 had behaviors of public disrobing. The assessment indicated R2 was socially inappropriate. During observation on November 26, 2022, at approximately 9:30 a.m., Investigator saw R2 in her room, under the covers of her bed. R2 was unable to recall her first name and referred to herself by different names and things. R3 admitted to the licensee on May 2, 2022. R3's diagnoses included major depression, post-traumatic stress disorder (PTSD), and suicide thoughts. R3's service agreement dated August 29, 2022, indicated R3 required assistance with behavior management, medication management, safety	0 630		

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0 630	Continued From page 6 checks, and housekeeping. R3's individualized abuse prevention plan (IAPP) dated November 21, 2022, indicated R3 used alcohol and street drugs. Including crack and methamphetamine. The assessment indicated the resident had prior suicide attempts. The assessment indicated staff would "monitor" R3. The assessment failed to identify specific, individualized plan for monitoring R3. The licensee's policy, 2.44 Vulnerable Adult Maltreatment Prevention and Reporting, dated August 1, 2021, indicated licensee would develop individualized vulnerable adult abuse preventions plans to identify vulnerability risks and develop measures to minimize maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02310 SS=J	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 provide appropriate care and services according to acceptable health care, medical, or nursing standards of practice for two of four residents (R1, R3), reviewed for drug overdose. The licensee failed to assess and monitor R1 for effects of drug overdose after they	02310		

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02310	Continued From page 7 removed drugs and paraphernalia from him. The resident was found deceased in his locked bedroom the following day at 2:00 p.m., approximately 17 hours after staff removed drugs and paraphernalia. The licensee failed to assess, monitor, and implement interventions to reduce R3's risk for injury after suicide risk and drug use was identified. This practice resulted in a level four violation (a violation that results in 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). Findings include: R1 admitted to the facility on February 3, 2022, with diagnoses including depression, anxiety, bipolar disorder, and hyperactivity disorder. R1's service agreement dated March 12, 2022, indicated R1 required assistance with medication administration, laundry, housekeeping, safety checks, dressing, behavior management, and meal assistance. R1's master care plan dated July 29, 2022, indicated R1 used THC, opiate, heroin, and methamphetamine drugs. The care plan indicated R1 had a history of drug overdose. The care plan indicated R1 was at risk high risk for suicide. The care plan indicated R1 was at high risk for drug overdose. R1's progress notes dated October 16, 2022, at 6:22 p.m., indicated registered nurse (RN)-B arrived at the facility at 2:00 p.m. on October 16,	02310		

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02310	Continued From page 8 2022, to assess R1 because he had aggressive behaviors on October 15, 2022, during the evening. The notes indicated R1 was aggressive after staff removed drugs and paraphernalia from him. R1 went to his room yelling and banging on the walls. The notes indicated R1 wanted to inject himself with fentanyl. The notes indicated RN-B went to check on R1 at 2:00 p.m., on October 16, 2022, and found him lying on the floor deceased. During an interview on November 17, 2022, at 4:07 p.m., unlicensed personnel (ULP)-E said he worked October 15, 2022, 7:00 p.m. to 7:00 a.m. ULP-E said he and owner (OW)-A removed drugs and paraphernalia from R1 at approximately 8:00 p.m. ULP-E said R1 returned to his room after getting juice, and went to sleep. ULP-E denied seeing R1 after that encounter but stood in the hallway at 2:00 a.m. and heard snoring noises. ULP-E said he did not see R1 or open his door. ULP-E said there were no changes made to R1's plan of care after they removed drugs and paraphernalia from R1. ULP-E said he left the facility at 7:00 a.m. the next morning. During an interview on November 17, 2022, at 3:32 p.m., ULP-D said he worked 7:00 a.m. to 7:00 p.m., on October 16, 2022. ULP-D said he was informed staff removed drugs and paraphernalia from R1 the evening prior. ULP-D denied seeing R1 during his shift until RN-B arrived at 2:00 p.m. R1's master care plan dated July 29, 2022, indicated R1 was violent toward himself and others when he did not have street drugs. The care plan indicated staff would check him every fifteen minutes when he was in his room. R1's record lacked any documented observations	02310		

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02310	Continued From page 9 or assessment of R1 after staff removed drugs and paraphernalia from his possession. R1's record lacked changes to plan of care after the incident. The licensee failed to implement measures to observe and assess R1 for drug overdose after they removed drugs and paraphernalia. R3 admitted to the facility on May 1, 2022, with diagnoses including suicide thoughts, major depression, and anxiety. R3's service agreement dated August 29, 2022, indicated R3 required assistance with behavior management, medication management, safety checks, and housekeeping. R3's admission assessment dated May 5, 2022, indicated R3 was hospitalized in the past for suicidal thoughts. The assessment indicated R3 had made multiple suicide attempts. The assessment indicated R3 was at risk for suicide and staff would remove sharp objects and utensils from her. The assessment indicated R3 used street drugs including methamphetamine and crack. The assessment indicated R3 drank heavy alcohol. The assessment indicated R3 became physically aggressive when she used street drugs. Facility incident report dated May 8, 2022, indicated R3 became violent with another resident, went to her room to obtain a knife, and taunted the resident with it. The incident report indicated the knife was "eventually retrieved". The incident report indicated staff calmed her down. The incident report lacked further interventions to monitor and assess resident's safety.	02310		

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02310	Continued From page 10 R3's progress notes failed to identify incident on May 8, 2022, and lacked subsequent follow up assessment, monitoring, or interventions. R3's progress notes dated May 10, 2022, at 6:41 p.m., indicated staff assessed R3 with drugs but denied R3 had any adverse effects. The progress notes lacked further assessment, or monitoring for adverse effects. R3's progress notes dated July 1, 2022, at 11:15 a.m., indicated R3 said aripiprazole made her depressed and think of suicide. The progress notes indicated facility staff would monitor R3. The progress notes failed to identify time and duration of monitoring. The progress notes failed to identify individualized interventions for suicide monitoring. R3's individualized abuse prevention plan (IAPP) dated November 21, 2022, indicated R3 used alcohol and street drugs. Including crack and methamphetamine. The assessment indicated the resident had prior suicide attempts. The assessment indicated staff would "monitor" R3. The assessment failed to identify specific, individualized plan for monitoring R3. The licensee's policy, 2.44 Vulnerable Adult Maltreatment Prevention and Reporting, dated August 1, 2021, indicated licensee would develop individualized vulnerable adult abuse preventions plans to identify vulnerability risks and develop measures to minimize maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35546	A. BUILDING: _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 11	02360		
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: Based on observations, interviews, and document review, the facility failed to ensure one of four residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report (sent separately) for details	