Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356837262M
Compliance #: HL356832303C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
Premium Home Healthcare LLC
6426 Fremont Ave North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
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(s):
The facility neglected the resident when they failed to provided supervision. The resident overdosed on drugs and died in the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident died from an overdose of drugs, the resident was independent with his decision-making with the right to come and go freely from the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a Forensic Assertive Community Treatment (FACT) Team nurse, and the case worker. The investigation included review of the resident record, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included multiple mental health diagnoses and substance abuse disorders. The resident's service plan included assistance with medication management and behavioral management. The resident's assessment indicated the resident was alert, oriented, and able to do his own cares with reminders as needed.

One morning an unlicensed caregiver attempted to check on the resident in his room, but he did not answer. Knowing the resident became upset when awoken for checks, the caregiver decided to wait and check on the resident later. About two hours later when the normal time for the resident to get up has past the caregiver tried again but with no answer. Due to growing concern, the caregiver entered the resident's room and found the resident laying on his bed having died from what appeared to be a drug overdose.

About two weeks prior to the resident's death, he moved into the facility. The assessment indicated attended an outpatient program for substance abuse. The same document indicated the resident had a history of noncompliance with a risk of elopement, so the facility arranged for the resident to sign-out when leaving the facility and to verify the resident's movement to and from the FACT Team. The assessment indicated the resident expressed he found checking on him bothersome, disturbing, and offensive especially at night or when he was sleeping, so the facility tried to reach a balance of providing supervision which would be acceptable to him.

The assessment also indicated the resident had denied current use of street drugs, was able to identify his supports, and said he was able to ask for help if he began to struggle with substance abuse.

The residents Individual Abuse Prevention Plan indicated the resident had a history of walking off within a day or two of being at a new facility. The resident would go to unknown places for days without contacting anyone and would not answer calls. The assessment indicated measurements to minimize risks included utilizing check-in/check-out logbook.

Progress notes indicated multiple occasions within the first ten days of the resident's stay at the facility that he became agitated or angry and yelled at staff when they knocked on his door. The notes indicated the resident yelled out to be left alone, did not like staff knocking on his door, and refused to open his door.

During an interview, a community nurse stated they had trouble finding the resident on the day of admit; however, when they did find him, he denied actively using substances at that time. The community nurse stated facility staff reached out to him after the resident did not return to the facility immediately following a meeting. The community nurse stated he told the facility staff to encourage independence upon the resident. When asked if the community nurse noticed a change in behavior prior to his death, the community nurse stated there were too many factors playing a role to determine if the residents change was related to drug use or just a change to his environment.

During an interview, the unlicensed caregiver stated he knocked on the resident's door early one morning and the resident did not respond. The caregiver stated it was normal for the resident to stay in his room late because he did not wake up early. The caregiver stated he went back to the resident's room later, knock on the door repeatedly, and got no response from the resident. The caregiver stated the resident would usually respond by this time. The caregiver stated he called his boss, got the spare key, and unlocked the door. The caregiver stated he found the resident, called his boss and 911. The caregiver stated the resident went outside for about ten minutes the evening prior, did not eat all his evening meal, refused his bedtime medications, and never came out of his room again. The caregiver stated he knocked on the resident's door to finish his evening meal and take his medications, but the resident yelled at him. The caregiver stated he did not notice a change in the residents' mood or activity the evening prior to the incident.

During an interview, a manager, who is also a nurse, stated she received a call from the unlicensed caregiver who needed the emergency key to enter the resident's room because he would not answer to the staff knocking on the door. The manager stated the caregiver found the resident lying on the bed with foam coming out of his mouth and called 911. The manager stated she was aware the resident had a history of drug use but was currently in a program and not actively using on admit. The manager stated the resident received safety checks but not during the night because he struggled with sleep and told her being checked on at night would trigger him. The manager stated the morning of the incident was a weekend and it was normal for the resident to sleep in. The manager also stated the resident had no change in behavior over the last few days prior to the incident.

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: No. The resident was deceased.

Family/Responsible Party interviewed: No. There were no family members or responsible parties listed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35683	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIUM HOME HEALTHCARE LLC	6424 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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 December 18, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL356832303C / HL356837262M. No correction orders are issued.	0 000		