DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36009001M
Compliance #: HL36009002C

Date Concluded: June 21, 2022

Name, Address, and County of Licensee Investigated:
Ashton Homes LLC
3840 Boone Avenue
Golden Valley, MN 55427
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, 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.

Allegation(s):
The facility neglected the resident when the facility failed to provide supervision and monitoring to ensure the resident's safety.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide adequate supervision to ensure the resident's safety. The resident eloped and was found over a mile away in freezing weather without a shirt or shoes on.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the resident's medical record, incident reports, staff schedules, and facility policies. In addition, the investigator reviewed the police report and resident's hospital records.

The resident received assisted living services for diagnoses that included schizoaffective disorder, pervasive development disorder, and attention deficit disorder. The resident received one to one staff supervision on day shift and evening shift. The resident had a history of physical and verbal aggression, and multiple elopements from the facility.

Review of law enforcement reports indicated between a nine-month span, the resident had eloped from the facility without a caregiver on seven different occasions. Each elopement was at various times, some during the night. Two elopement incident law enforcement was unable to locate the resident until he returned to the facility on his own and staff notified law enforcement of his return. In addition, to the elopements during this period there were six other law enforcement reports responding to violent or suicidal episodes of the resident and required transportation to the hospital.

According to the law enforcement report of the seventh elopement, an employee at a church reported the resident outside without a shirt or shoes on. When the police arrived, the resident was inside the church extremely agitated. The resident was verbally and physically aggressive towards the police officer. The resident attempted to take the police officers gun and hit the officer in the face. The police report indicated the resident made delusional statements.

During an interview with the resident's guardian said she went to visit the resident the day of the incident. The guardian said the resident was missing when she arrived. The guardian said staff told her the resident went for a walk. The guardian said the resident requires one staff to always be with the resident at all times. The guardian said the staff said they did not follow the resident because he was the only staff working at the time and he could not leave the other residents alone. The guardian said other residents live at the facility. The guardian said the church staff called the police. The guardian said the director told her he moved the second staff assigned to work at the resident's facility, to another site.

In consultation with the cadi case manager, the case manager said the resident should have at least one staff with him at all times. The cadi case manager said the resident is very aggressive and needs constant supervision and redirection. The cadi case manager said the facility has failed to provide adequate supervision and interventions to ensure the resident's safety.

During an interview, nurse 1 said one staff is assigned to the resident at all times. Nurse 1 said the resident has never had two staff assigned to him. Nurse 1 said there are always two staff scheduled at the facility. One staff is assigned to supervise the resident and the other staff is assigned to care for the other three residents that live at the facility. Nurse 1 said staff are trained to follow the resident and call 911 when the resident leaves the facility.

During an interview, nurse 2 said the facility needed a minimum of two staff, one staff assigned to the resident and one staff to monitor the other residents in the facility. Nurse 2 said the facility had been short staffed numerous times when she worked there. Nurse 2 said one staff had worked at the facility alone multiple times.

During interviews with unlicensed personnel (ULP), both staff gave conflicting statements. ULP 1 said he was assigned to the resident the day of the incident. ULP 1 said he followed the resident and attempted to redirect the resident, but the resident refused redirection. ULP 1 member said he called the police and reported the incident. ULP 1 said the police said they found the resident in the park. ULP 1 said ULP 2 worked with him the evening of the incident. ULP 1 said he saw the manager onsite after the incident. ULP 1 said he did not see the guardian the evening of the incident. ULP 2 said him and ULP 1 both worked the entire evening together. ULP 2 said ULP 1 followed the resident when the resident left and then returned to the house without the resident. ULP 2 said they called the police. ULP 2 said he did not see the resident's guardian the evening of the incident. ULP 2 said he did not see the manager the evening of the incident.

During an interview, the manager said he went to the facility the evening of the incident. The manager said the guardian was at the facility for a scheduled meeting with the resident. The manager said only one staff member was working at the time of the incident. The manager said the facility is hard to staff and at times there has been one staff working alone with the resident and other residents. The manager said there was one time he worked alone at the facility because there was no other staff available. The manager said two staff are scheduled on days and evening and one staff is scheduled during the night shift.

According to an email sent by the facility to the cadi case manager on March 16, 2021, the facility indicated the resident needed more than one staff to keep him safe. The facility indicated the resident was physically aggressive towards staff and damaged property.

According to the Coordinated Services and Supports Plan the resident received 2:1 and 1:1 staffing at all times to ensure his safety. The provider will provide 24-hour support and supervision with 1:1 staffing supports to meet the needs in behavioral/ mental health area. If the resident engages in unsafe choices additional staff will be added.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, due to mental health.
Family/Responsible Party interviewed: Yes, legal guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
An incident report was completed. The facility completed a change in condition assessment seven days prior to the seventh elopement incident.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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
Golden valley City Attorney
Golden Valley Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36009	A. BUILDING: ______ B. WING ______	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HOMES LLC	**3840 BOONE AVENUE NORTH NEW HOPE, MN 55427**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, the correction order is 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: HL36009002C/#HL36009001M On May 11, 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 four clients receiving services under the provider's Assisted Living license. The following correction order is issued for HL36009002C/#HL36009001M, tag identification 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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

Minnesota Department of Health

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02360	Continued From page 1 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 interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On June 21, 2022, 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. MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No plan of correction required. Please refere to public maltreatment report (sent separately) for details.	