Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362048848M
Compliance #: HL362046453C

Date Concluded: May 16, 2024

Name, Address, and County of Licensee Investigated:

Armstrong Homes LLC
7908 Oregon Avenue North
Brooklyn Park, MN 55445
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 the resident was found deceased in his room from an apparent 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 in accordance with the resident's service plan and failed to develop and implement resident specific interventions to ensure the resident's safety. Despite known vulnerabilities, facility staff were not directed to monitor the resident or educated on interventions to manage the resident's refusals to take mental health medication. As a result, the resident increased his alcohol intake, marijuana use, and used illicit street drugs while at the facility. The resident was found deceased in his room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and two of

the resident's case workers. The investigation included review of the resident's records, death record, facility incident reports, a law enforcement report, and related facility policies and procedures. At the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, major depressive disorder, and suicidal ideation. The resident's service plan included assistance with dressing, grooming, bathing, medication management, and a daily "I'm OK" check. The resident's assessment indicated the resident had a history of alcohol, chemical and/or other medication abuse, and daily alcohol and marijuana use. Despite these known vulnerabilities, no interventions were created or implemented to protect the resident's safety.

The resident's medical record indicated the resident started refusing his mental health medications. The resident told staff he felt better without the medications, and increased his marijuana use as a substitution for the medications. Staff advised the resident to contact his medical provider about discontinuing his mental health medications. Staff documented in the resident's medical record the resident had increased agitation, was frequently intoxicated, had been isolating in his room, and expressed concerns about suicidal thoughts.

Approximately two weeks later, staff found the resident unresponsive in his room and contacted police.

Review of a police report indicated officers were dispatched to the facility at 12:50 p.m. because the resident was not breathing or moving. When officers arrived, they found the resident lying across the top of his bed, cold to the touch, and rigor mortis (stiffening of the joints and muscles of a body) had set in. The police report indicated that the resident was out in the facility garage the night before his death, drinking and smoking marijuana with another resident. While in the garage, the resident was observed crushing a substance and snorting it. The police report indicated there were discrepancies in the staff's accounts of when the resident was last seen alive; however, the resident was last witnessed on the facility's camera footage going into his room around 8:45 p.m. The police report indicated a powder-like substance was observed on the resident's bedside table, and beer cans and drug paraphernalia used to smoke marijuana, were also found throughout the resident's room.

The resident's death record identified the resident's manner of death was accidental due to a mixed drug toxicity of fentanyl (opioid), xylazine (a non-opioid sedative or tranquilizer), and ethanol.

Facility staff did not update the resident's provider, complete an assessment, or develop interventions, despite their knowledge of the resident's refusal of medications, increase in marijuana and alcohol use, increase in agitation, and expression of suicidal thoughts.

During an interview, facility management stated the resident had a history of suicidal ideations and was depressed. Facility management stated that when the resident decided to stop taking his medications, about two to three weeks before he died, everything changed. The resident started drinking and smoking marijuana often and became increasingly agitated. Facility management stated it was hard to get in touch with the provider, so facility staff documented the refusals on the medication administration record and updated the resident's mental health case manager. Facility management stated that staff were supposed to check the resident's belongings for drugs and alcohol and the resident was not allowed to drink alcohol or smoke marijuana at the facility. Facility management stated the company policy was to complete safety checks on the resident every two hours; however, he could not confirm if safety checks were completed. Facility management also stated that staff received annual training, but staff were not trained on specific interventions for the resident.

During an interview, the resident's case manager stated that the resident was admitted to the facility after hospitalizations related to mental health concerns and substance abuse. The resident requested to move into the facility because he had heard from another resident that there was more freedom there than at the facility he was living at prior. The case manager stated the facility nurse did not reach out regarding the resident's refusal of medications and in a meeting with the resident days before his passing, no concerns were reported.

The facility nurse and staff who worked at the time of the incident were no longer employed at the facility and did not respond to requests for interview.

Attempts to interview the resident's mental health provider were unsuccessful.

In conclusion, the Minnesota Department of Health determined 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 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, deceased.
Family/Responsible Party interviewed: No, attempts were not successful.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called 911 when the resident was found unresponsive.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	C 03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER 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: #HL362046453C /# HL362048848M On March 11, 2024, 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 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued for # HL362046453C /# HL362048848M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State 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 Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	