

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368877422M
Compliance #: HL368872642C

Date Concluded: March 24, 2025

Name, Address, and County of Licensee

Investigated:

Prime Care Services
484 E. Page Street, Unit B
Saint Paul, MN 55107
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, 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 they failed to provide supervision and monitoring to ensure the resident was safe. The resident eloped from the facility and 16 days later was found deceased from a drug overdose.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had a well-known history of substance abuse, wandering, and impulsivity, yet the facility did not take reasonable steps to supervise the resident to ensure his well-being and safety. Overnight unlicensed personnel and morning incoming unlicensed personnel both arrived late for work and never checked the resident's room or facility to ensure the resident was in the facility which delayed the opportunity to immediately begin searching for the resident. The resident went unaccounted for until 12 hours later when the resident's family member arrived at the facility and requested staff check to see if the resident was in his room. In addition, unlicensed personnel slept during overnight shifts.

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The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed personnel. The investigator interviewed the resident's family member, mental health practitioner, and case manager. The investigation included review of the resident's facility record, external medical records, death record, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in an assisted living with diagnoses that included substance use disorder, fetal alcohol syndrome, intellectual disability, attention-deficit hyperactivity disorder (ADHD), and depression. The resident transferred to the assisted living from a previous supervised living facility. Upon admission to the facility, the resident was sober. The resident required staff supervision due to the resident's history of several elopements from other facilities and use of drugs, wandering, and was easily manipulated by others. Staff were to remain vigilant and keep the resident within sight at all times while around the resident. When the resident admitted to the facility the resident had a conditional release that required staff supervision while out in the community and in the facility. The resident was prescribed daily antipsychotic medications. The resident was alert, oriented, and able to make his needs known. The resident walked independently. The resident's service plan indicated he received daily assistance with his personal cares, monitoring, medication administration and behaviors.

The resident's record had no current behavior plan completed by the facility including a plan for staff supervision of the resident.

The facility schedule indicated one staff were scheduled for each of three shifts a day.

A progress note indicated one day an evening shift unlicensed personnel indicated the resident was last seen when the resident took his scheduled 8:00 p.m. medications and went to his room. At 11:00 p.m., the evening unlicensed clocked out and left the facility.

The facility's electronic employee clock in and clock out data sheet indicated the night shift unlicensed personnel clocked in over an hour late and after the evening unlicensed staff left the facility, leaving the facility unsupervised by facility staff. In addition, the night shift unlicensed personnel clocked out early before the day shift unlicensed staff personnel arrived for work again leaving the residents in the facility unsupervised.

The evening shift unlicensed personnel, the night shift unlicensed personnel, and the following day shift unlicensed personnel failed to perform a shift change report with the previous shift to ensure the resident was accounted for. In addition, when the resident was unaccounted for by the day shift unlicensed personnel, they failed investigate and notify facility leadership which delayed the opportunity for staff to begin an immediate search for the resident.

When interviewed, the resident's case manager stated the resident was very vulnerable.

When interviewed, multiple staff stated they were allowed to sleep during the overnight shift.

When interviewed, the day shift unlicensed personnel stated staff were expected to perform safety checks (room checks) at the start of each shift, document everything they did during the shift, and conduct a shift change report to oncoming staff. The day shift unlicensed personnel stated she clocked in late to work that morning shift, stating the prior night shift unlicensed personnel was not there when she arrived at the facility. The day shift unlicensed personnel stated shortly after she arrived another resident came downstairs stating he did not see the resident that morning. The day shift unlicensed personnel stated she went upstairs to the resident's room, knocked and opened the resident's door noticing the resident was not in his room. The day shift unlicensed personnel stated she was not concerned and never notified leadership, thinking the resident was out visiting his family member even though she stated it was unusual for the resident not to greet her when she arrived for work. The day shift unlicensed personnel stated it would not be difficult for the resident to leave unnoticed since the overnight shift was a "sleepover shift," stating staff would come in and sleep during the night and be unaware of what the residents were doing. When asked if leadership was aware staff slept, the day shift unlicensed personnel stated, "Well, it's a sleepover shift. Yeah, the shift itself is a sleepover shift." I'm assuming it's well known that staff sleep."

When interviewed, the night shift unlicensed personnel stated she clocked in late for the overnight shift and did not check to see the resident was in his room when she arrived for work. The night shift unlicensed personnel stated even if she slept during the overnight shift the resident was able to leave the facility whenever he wanted to because it was his right.

When interviewed, leadership stated the resident had poor decision-making and self-preservation skills. Leadership stated the resident was his own guardian and had no formalized plan he had to have "eyes" on him 24/7 stating, "There is awake staff in the house 24/7 anyway." Leadership stated they feared the resident would get back on the streets and take drugs because he was newly sober, so staff accompanied him for a few months then stopped. Leadership stated the facility conducted an internal investigation around the resident's elopement and stated they would provide their internal investigation report to the investigator. An internal investigation report was never provided. Leadership stated the resident's death was unexpected even though he had a history of eloping and living on the streets.

When interviewed, the resident's family member stated one Saturday she and another family member and friends were going to pick up the resident to take him to a movie. That morning, the family member became concerned when the resident did not call her several times before 9:00 a.m. which was the resident's daily routine. The family member stated she called the resident multiple times, but he did not answer. At 12:00 p.m. the family member went to the facility, but staff did not know the resident's whereabouts. The family member stated, "This was noon, and the staff did not see him or report him missing." The family member stated staff

confirmed the resident took his evening medications but not morning medications and they did not know when he left the facility, stating staff said the resident had a right to leave whenever he wanted to. The family member stated the facility knew the resident required close supervision, "Staff informed me he would have 1:1 supervision at all times."

The police report indicated 16 days after the resident left the facility, police were dispatched to an apartment building where they found the resident deceased in the stairwell. Drug paraphernalia was found next to the resident.

The resident's death certificate indicated his immediate cause of death was fentanyl toxicity.

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 1.

"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 vulnerable adult is deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility contacted the police department and conducted a search.

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>

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

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

Ramsey County Attorney

Saint Paul City Attorney

Saint Paul Police Department

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2025
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NAME OF PROVIDER OR SUPPLIER PRIME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 484 PAGE STREET EAST UNIT B SAINT PAUL, MN 55107
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL368872642C/#HL368877422M</p> <p>On February 11, 2025, 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 two residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL368872642C/#HL368877422M, tag identification 2349 and 2360.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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02310	Continued From page 1	02310		
02310 SS=J	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they provided adequate supervision and monitoring for one of one residents (R1) with record reviewed to ensure he was in the facility and safe. For over an hour during the overnight shift the licensee failed to ensure they had staff in the facility which left R1 unsupervised and able to leave the facility unnoticed. In addition, multiple staff stated the overnight shift was a sleep shift for staff to sleep. Unlicensed personnel (ULP)-F stated she never performed a room check to see if R1 was in his room when she arrived late for the overnight shift. Sometime during the overnight shift R1 left the facility. Police found him 16 days later deceased from a fentanyl overdose.</p> <p>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).</p> <p>The findings include:</p> <p>R1's behavior plan dated June 1, 2024, and prior to his admission to the facility, indicated R1 had a</p>	02310	<p>RECEIVED A REQUEST FOR RECONSIDERATION</p>	

Minnesota Department of Health

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02310	<p>Continued From page 2</p> <p>history of risky, impulsive behaviors, suddenly taking off, living in the streets, and heavily using substances. Triggers identified included discomfort with his living situation, feeling constrained, and "most importantly, boredom." Staff were to regularly check-in with R1 to ensure his safety, monitor for signs of substance use as well as mood or conduct changes.</p> <p>R1's record indicated from June 19, 2023 through July 14, 2024, R1 received supportive services and housing from the licensee under another license they held. During that year R1 eloped multiple times from their facility, lived on the streets, actively used street drugs, and was in and out of jail. After his last release from jail R1 moved into the licensee's assisted living facility under conditional release he would always be supervised while out in the community and in the facility.</p> <p>R1's medical record was reviewed. R1 was admitted to the licensee's assisted living facility on July 15, 2024. R1's diagnoses included but were not limited to Fetal Alcohol Syndrome, attention-deficit hyperactivity disorder (ADHD), substance abuse, intellectual disability, and depression. The assisted living facility was a duplex, Unit B and the other side of the duplex, Unit A was the licensee's community residential setting (CRS) license which was licensed by the Department of Human Services (DHS).</p> <p>R1's service plan dated July 15, 2024, indicated R1 received daily assistance with his personal cares, monitoring, medication administration, meals three times a day, and behaviors. The facility did not establish a system for staff to document they provided all the resident's services and for leadership to monitor and verify if the</p>	02310	<p>RECEIVED A REQUEST FOR RECONSIDERATION</p>	
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02310	<p>Continued From page 3</p> <p>resident actually received all his required services indicated in his service plan and record.</p> <p>R1's record lacked evidence of staff documentation of R1's services that were provided and a way for leadership to ensure R1 received his required services.</p> <p>R1's individual abuse prevention plan (IAPP) dated July 15, 2024, indicated the resident had a history of substance abuse and impulsivity. The resident was vulnerable to be influenced by others to abuse illegal drugs. Staff were to remain vigilant and keep the resident within sight at all times while around the resident. The IAPP directed staff to remain with R1 when he was out in the community and monitor for dangerous situations, redirecting R1 away from any situation and help R1 remove himself.</p> <p>R1's assessment dated July 15, 2024, indicated R1 was impulsive with diminished judgement and easily manipulated, indicating "It's very easy for him to find trouble even when he's trying not to."</p> <p>R1's behavioral provider's note dated October 7, 2024, at 1:30 p.m., indicated R1 reported boredom at the facility stating he did not get out of the facility that often.</p> <p>In emails between family member (FM)-B and R1's case manager (CM)-G, dated October 18, 2024, at 10:50 a.m., indicated FM-B was worried the facility was not providing the resident's services. FM-B indicated the facility was not "doing anything" to keep R1 engaged and R1 was "completely bored all the time." FM-B expressed concern the facility was not the ideal setting for R1 since he was so early his drug recovery. FM-B indicated R1 was still a flight risk which increased</p>	02310	<p>RECEIVED A REQUEST FOR RECONSIDERATION</p>	
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02310	<p>Continued From page 4</p> <p>when R1 had nothing to do on a daily basis. FM-B shared she visited R1 often during the week, so that R1 had things to do but indicated there was only so much she was able to help with. CM-G indicated he would look at other housing options to better suit R1 if the facility was not receptive to FM-B's concerns.</p> <p>Another behavioral provider note dated November 4, 2024, at 1:30 p.m., indicated R1's family member (FM)-B was looking into other housing options for the resident because R1's needs were not being met at the facility.</p> <p>R1's progress note dated November 22, 2024, and documented by evening shift unlicensed personnel (ULP)-D, indicated R1 was last seen prior to ULP-D's shift ending at 11:00 p.m. ULP-D documented R1 took his scheduled 8:00 p.m. medications then went back to his room. On November 22, 2024, at 11:00 p.m., ULP-D clocked out and left the facility.</p> <p>Review of the facility's electronic employee time sheets dated November 22, 2024 through November 23, 2024, indicated on November 23, 2024, at 12:07 a.m., on the left-hand side of the electronic document, ULP-F clocked in to work the overnight shift indicating from November 22, 2024, at 11:00 p.m. until November 23, 2024, at 12:07 a.m. there were no staff in the facility to monitor R1 which left R1 unsupervised and able to leave unattended. In addition, on November 23, 2024, at 8:57 a.m., ULP-F clocked out and left the facility at 8:57 a.m. before ULP-E arrived to work the morning shift.</p> <p>R1's record lacked documentation ULP-F wrote a progress note documenting she checked to see if R1 was in his room when she arrived for work</p>	02310	<p>PROCESSED AND REQUEST FOR RECONSIDERATION</p>	
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02310	<p>Continued From page 5</p> <p>and never performed shift change report with ULP-E to let her know if R1 was in the facility.</p> <p>R1's police report, dated December 8, 2024, (16 days after R1 went missing) at 12:54 a.m., indicated police were dispatched to an apartment building after being advised R1 was on the stairwell using drugs. Medics arrived and pronounced R1 dead at 1:09 a.m. Police found drug paraphernalia next to R1.</p> <p>In an email dated between February 12, 2025, at 3:48 p.m. from the Minnesota Department of Health (MDH) investigator to LALD-A, the investigator requested a document staff check off when they perform a service for R1. At 3:59 p.m. LALD-A responded indicating staff documented detailed progress notes containing every service staff delivered for each resident. At 4:22 p.m. the investigator replied indicating review of R1's progress notes lacked evidence staff provided R1's services.</p> <p>During an interview on February 12, 2025, at 9:00 a.m., LALD-A stated R1 had poor decision-making and self-preservation skills. LALD-A stated R1 was his own guardian and had no formalized plan he had to have "eyes" on him 24/7 stating, "There is awake staff in the house 24/7 anyway." LALD-A stated they feared R1 would get back on the streets and do drugs because R1 was newly sober, so staff initially supervised R1 everywhere but that was no longer an intervention for R1. LALD-A stated on November 23, 2024, at 8:00 a.m., ULP-E noticed R1 was not in his room during 8:00 a.m. medication pass. LALD-A stated the facility was not a locked facility and residents were able to come and go at will. LALD-A stated ULP-F left the overnight shift without documenting a progress</p>	02310	<p>RECEIVED A REQUEST FOR RECONSIDERATION</p>	
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02310	<p>Continued From page 6</p> <p>note and was unaware of what ULP-F did during the shift since she never documented a progress note. LALD-A stated the facility conducted an internal investigation around R1's incident stating she would provide the internal investigation report to the MDH investigator. (An internal investigation report was never provided. LALD-A stated R1's death was unexpected even though he had a history of eloping and living on the streets.</p> <p>During an interview on February 12, 2025, at 1:00 p.m., FM-B stated two months before R1 eloped, R1 told her he could not live at the facility because he was bored. FM-B stated she visited R1 more often at the facility when things became too uncomfortable for him there and worried about R1 because he was a flight risk due to developmental disabilities. FM-B stated on November 23, 2024, she and another family member and friends were going to take R1 to see the movie. FM-B stated she became concerned when R1 did not call her stating he used to call her multiple times before 9:00 a.m. FM-B stated she called R1 multiple times, but he did not answer. FM-B stated at 12:00 p.m. (approximately 16 hours after staff interaction with R1) she went to the facility and stated staff did not know R1's whereabouts. FM-B stated, "This was noon, and the staff did not see him or report him missing." FM-B stated staff confirmed R1 on November 22, 2024 took his evening medications but not his November 23, 2024 morning medications. Staff stated they did not know when R1 left the facility and told FM-B R1 had a right to leave whenever he wanted to. FM-B stated she wondered how R1 was able to leave the facility without staff seeing him leave.</p> <p>In an email dated February 13, 2025, at 5:01 p.m., from LALD-A to the MDH investigator,</p>	02310	<p style="font-size: 2em; transform: rotate(-45deg); opacity: 0.5;">RECEIVED A REQUEST FOR RECONSIDERATION</p>	
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02310	<p>Continued From page 7</p> <p>(LALD)-A indicated the time on the left-hand side of the employee time sheets indicated the actual time staff clocked in for their shift. LALD-A stated there was one staff scheduled for the Unit B per shift.</p> <p>During an interview on February 25, 2025, at 12:00 p.m., ULP-E stated staff were expected to perform safety checks (room checks) at the start of each shift, document everything they did during the shift, and conduct a shift change report to oncoming staff. ULP-E stated on November 23, 2024, she clocked in late for her 9:00 a.m. shift and stated ULP-F was not there when she arrived at the facility. ULP-E stated shortly after she arrived another resident came downstairs stating he did not see R1 that morning. ULP-E stated she went upstairs to R1's room, knocked and opened his door noticing R1 was not in his room. ULP-E stated she was not concerned and never notified facility management because she thought R1 went to visit FM-B the day before. ULP-E stated it would not be difficult for R1 to leave unnoticed since the overnight shift was a "sleepover shift," stating staff would come in and sleep and be unaware of what the residents were doing. When asked facility management was aware staff slept ULP-E stated, "Well, it's a sleepover shift. Yeah, the shift itself is a sleepover shift." I'm assuming it's well known that staff sleep."</p> <p>During an interview on February 25, 2025, at 3:14 p.m., ULP-F stated on November 23, 2024, she clocked in late for the overnight shift and did not check to see if R 1 was in his room when she arrived for work. ULP-F stated even if she slept during the overnight shift R1 was able to leave the facility whenever he wanted to because it was his right.</p>	02310	<p style="font-size: 2em; transform: rotate(-45deg); opacity: 0.5;">RECEIVED A REQUEST FOR RECONSIDERATION</p>	
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2025
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NAME OF PROVIDER OR SUPPLIER PRIME CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 484 PAGE STREET EAST UNIT B SAINT PAUL, MN 55107
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(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
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02310	<p>Continued From page 8</p> <p>During an interview on February 27, 2025, at 11:00 a.m., CM-G stated R1 was very vulnerable.</p> <p>In an email dated March 3, 2025, from FM-B to (MDH) investigator, FM-B indicated the licensee knew R1 required close supervision. FM-B indicated, "Staff informed me he would have 1:1 supervision at all times."</p> <p>The licensee policy titled, Missing Resident, undated, stated when a resident is not where they can reasonable be expected to be (for example, not in the resident's home or apartment) staff promptly implements the missing resident procedure. 1. b. if the resident is not on a planned absence, make a prompt and thorough search of the home and surrounding area (building). If the resident is not located, i. Notify the Assisted Living Director and/or RN who takes charge of the situation. ii. Follow their instructions about making the following notifications: Notify the resident's representative, if any, and/or emergency contact person. Notify police with a description of the person and photo, if available. Inform them of the name of the resident, date and time they were last seen, clothing they were wearing, name of the primary contact or designated representative. iii. Make extensive search of the surrounding area and follow instructions given by law enforcement and RN/Assisted Living Director. Additional staff is called in to assist as necessary.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days.</p>	02310	<p style="font-size: 2em; transform: rotate(-45deg); opacity: 0.5;">RECEIVED A REQUEST FOR RECONSIDERATION</p>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial</p>	02360		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36887	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2025
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02360	<p>Continued From page 9</p> <p>exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p>	02360	<p>RECEIVED A REQUEST FOR RECONSIDERATION</p>	
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