Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371267102M
Compliance #: HL371261801C

Date Concluded: January 22, 2025

Name, Address, and County of Licensee Investigated:
St. Johns Home Care
10805 South Shore Drive
Plymouth, MN 55441
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP), facility nurse/owner, neglected a resident when they did not make changes to the resident's care plan and secure and dispense the resident's medications when issues of the resident abusing medications was assessed. The resident overdosed on self-administered Gabapentin (anticonvulsant) and required emergency medical assistance.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP assessed the resident at risk for abusing medications especially Gabapentin however, determined the resident was safe to self-administer medications. Nursing documentation lacked evidence that a reassessment of the resident's inability to safely self-administer medication was completed, nor was the medication removed from the resident's possession.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident's case manager. The investigation included review of resident and employee records, and facility policies and procedures. The investigator made an on-site visit to observe the facility.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, major depression, post-traumatic stress disorder, and psychotic disorder with delusions (state of mental illness where a person holds firmly onto false beliefs or delusions.) The resident's service plan included assistance with behavior monitoring. The resident's vulnerabilities included alcohol abuse, and chemical and/or medication abuse and self-abuse. The resident had periods of feeling overwhelmed, depressed, and anxious. Staff were directed to monitor the resident for risky behaviors with prescription medications and self-abuse and report concerns promptly to the nurse.

The resident's record indicated one month prior to the resident's Gabapentin overdose; the AP documented she was concerned the resident was abusing Gabapentin. The record lacked evidence of follow-up or interventions with the AP's concerns of the resident's misuse of medication.

One early morning the resident called a help line and told them she ingested an undetermined amount of Gabapentin. The help line instructed the resident call 911. While waiting for the ambulance, a staff member was notified of what was happening. Paramedics arrived and transported the resident to the hospital for an evaluation. Later that same day, the resident was admitted to the hospital for 10 days for a mental health crisis.

During an interview, the AP stated the resident was independent, did not want help from staff and self-administered her medications. AP stated although the resident was unhappy and anxious, the AP did not see "red flags" that would indicate the resident was going to harm herself even though the AP documented concerns with the resident abusing medications a month earlier. When questioned about appropriate staffing to assist the resident with medication administration, the AP stated she did not have enough staff and had to work herself to fill the shortages.

During an interview, the resident stated she set-up her medications in a weekly planner and self-administered them. The resident stated her significant other lived with her at the facility and would remind the resident to take the medications. The resident stated her significant other did everything for her because staff members were seldom present. On the day of the incident, the resident stated she was anxious and not feeling safe and wanted to be at peace, so she took a hand full of gabapentin to kill herself.

During an interview, the resident's significant other stated he lived at the facility and staff were not present 24 hours a day, and that they were "hardly there." The significant other stated at the beginning the resident managed her medications well. The significant other stated later the

resident became verbally aggressive, and he was concerned the resident was headed toward a crisis.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, they declined to be tape recorded.

Action taken by facility:
No action was taken. The resident moved out after discharge from hospital. No residents remain at this location.

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

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
Hennepin County Attorney
Plymouth City Attorney
Plymouth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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****** HOME CARE PROVIDER/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: #HL371261801C/#HL371267102M On December 9, 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 0 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued that were not issued at the time of immediate correction orders. The following correction order is issued/orders are issued for #HL371261801C/#HL371267102M, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOME CARE LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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
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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		