Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL372222600M
Compliance #: HL372229501C

Date Concluded: July 23, 2026

Name, Address, and County of Licensee Investigated:
Push Services Inc
4757 Louisiana Ave North
Crystal, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal, 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 the resident was found disoriented, slurred speech, and unsteadiness and discovered 48 tablets of alprazolam (a fast-acting sedative) were unaccounted. The resident required further examination at the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although 48 tablets of alprazolam were missing, the facility followed the resident's care plan and prescriber's orders. The facility assessed the resident was not safe to take medication independently however the resident and prescriber determined the resident was safe to manage alprazolam and other as-needed medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the provider, case manager, and pharmacy. The investigation included a review of the resident's facility, hospital, county, and

pharmacy records; the facility's internal investigation; incident reports; personnel files; staff training; staff schedules; and related facility policies and procedures. The investigator also observed care and interactions between residents and staff at the facility.

The resident lived in an assisted living facility with diagnoses including dissociative identity disorder (separate identities that think, feel, and act like different alternate identities or “alters”). Other diagnoses included post-traumatic stress disorder, bipolar disorder, epilepsy, and diabetes. The care plan included help with scheduled medication while the resident was allowed to manage as-needed medications on his own and received behavior support. The facility assessment showed the resident was not safe to take medications by himself because of a history of self-harm and missing medication. The assessment also showed the resident made their own decisions and no one else was authorized or appointed to make decisions for him.

A facility incident report noted a sudden change in the resident’s condition. Staff observed slurred speech, drowsiness, disorientation, and unsteadiness. During the evaluation, staff counted the resident’s alprazolam supply and discovered 48 tablets missing since the previous day. The resident denied ingesting the tablets but could not describe symptoms or provide further information. The resident agreed to a hospital evaluation.

Hospital records indicated that the resident reported increased anxiety and disorientation because of a facility fire drill, not a medication overdose. The resident said their three alters became frantic during the fire drill and admitted taking two tablets of alprazolam afterward. They acknowledged not feeling like themselves and described feeling “spaced out,” like post-seizure, but did not recall a seizure. Providers completed an examination and lab work. They found no evidence of toxic ingestion, overdose, or other concerns requiring hospitalization. Lab results suggested a possible urinary tract infection or electrolyte imbalance. The resident remained stable and was discharged back to the facility. Discharge documents indicated the reason for the visit was confusion and anxiety.

The resident’s progress notes indicated facility staff notified the prescriber of the incident, the resident’s change in condition and missing alprazolam. Staff also reported the resident was hospitalized and that they removed all medication from the bedroom. The facility requested a meeting with the resident and provider for the next business day. The following day, the team met with the resident. The prescriber continued to believe the resident could safely manage alprazolam and other as-needed medications; however, the facility continued to express concern. The team agreed to compromise and supply one week of medication at a time, rather than the full bottle, up to 120 tablets.

The residents’ progress notes indicated four days before the incident, the resident called administration after hours to report a seizure. Administration recommended hospital evaluation, but the resident declined. The next day, the resident told administration that no seizure had occurred and reported that an alter personality had instructed them to take an unknown amount of medication to end their life.

During the investigation, the resident showed the investigator the medication box in their bedroom. The resident pointed out missing slots and said the alprazolam was in the wrong places because the nurse could not count properly. The nurse said the resident moved the alprazolam to different days and times inside the box. Facility administration and nursing remained concerned about the resident's self-management of as-needed medication but could not change the prescriber's orders and continued to focus on safety.

During interview, the resident reported staff did not count or administer the medication correctly. The resident denied taking 48 tablets of alprazolam, stating they would not have left the hospital that quickly. The resident denied misplacing the medication or that another resident or alter obtained it.

During interview, the prescriber reported that, during a phone call with the resident in the emergency department, the resident spoke coherently and denied taking 48 tablets. The provider did not know what happened but believed the resident could not have cleared 48 tablets of alprazolam so quickly. The provider maintained the goal of resident self-administration for as-needed medication and continued to believe the resident was competent and at no risk managing their own medication.

During interview, facility administration stated the resident was independent and their own decision-maker, which challenged efforts to ensure the resident's medication safety. The facility continued attempts to implement a safe plan for the resident, but it proved untenable.

During interviews, case managers stated the resident had a history of unaccounted-for medication after the resident reported that an alter took some pills but did not know the amount. The case managers said the resident was usually alert and oriented. However, she could be forgetful due to severe and persistent mental health diagnoses.

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: Yes
Family/Responsible Party interviewed: Not Applicable
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility obtained emergency services for the resident and removed medication from the resident's bedroom.

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
	37222	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUSH SERVICES INC	4757 LOUISIANA AVENUE NORTH CRYSTAL, MN 55428

(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 July 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL372222600M/ HL372229501C. No correction orders are issued.	0 000		