Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL405661220M
Compliance #: HL405661663C

Date Concluded: April 17, 2025

Name, Address, and County of Licensee Investigated:
First Light Residential Care
801 East 84th Street
Bloomington MN, 55420
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
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 a resident when they failed to provide supervision after they gave him their only key to his room. As a result, staff could not enter his room and called law enforcement who arrived and found the resident deceased.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the facility gave the resident their only remaining room key, this did not contribute to the resident's death. Staff observed the resident prior to his death and his behavior appeared at his baseline. When the resident failed to respond to staff reapproach with evening medication, staff found an alternative way to view the resident in his room and called for emergency services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law

enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration, the resident's room, and facility documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia. The resident's service plan included assistance with grooming, housekeeping, laundry, and behavior management. The resident's nursing assessment indicated he was alert, orientated, and independent with all mobility. The resident had a history of using street drugs such as marijuana and cocaine, but the resident's record did not indicate there was current use.

The resident's progress notes indicated he lost his room key and wanted another one, however the facility only had one room key. The progress notes indicated the resident insisted on getting a room key, so the facility gave it to him. The next day, the resident took a nap early in the evening and staff heard him "snoring" approximately four hours later. Another staff member arrived at the facility approximately two hours later and knocked on the resident's door, but the resident did not respond. The progress notes indicated the staff member went outside to look through the resident's window and he was unresponsive. The staff called emergency services (911), and they determined the resident was deceased.

Law enforcement records indicated the resident had drug paraphernalia (equipment) on the bed next to him. A staff member told law enforcement she observed the resident in the early evening, and he asked for cookies but then went back to his room. The records indicated another resident saw him during the day but could not remember the time.

At the time of this investigation the medical examiner cause of death was not available.

During an interview, a manager said the resident walked by himself and left the facility on his own accord. The manager said the resident had paranoia (distrust of others) and did not like others disturbing him. The manager said the resident left the facility to go into the community (with another resident) one day prior to his death, however the following day nothing seemed unusual. The resident went to his room early in the evening around supper time. A staff member went to the resident's room later in the evening to give him medications and heard "snoring" sounds, so she did not disturb him. The manager said another staff arrived approximately two hours later and knocked on the resident's bedroom door, but he did not respond. A staff member checked on the resident through an outside window and saw him lying in his bed, unresponsive. A staff member called 911 and law enforcement broke the resident's door and found him deceased. The manager said the resident did not have a history of drug overdoses and the facility was unaware he was using street drugs. The manger said the facility will no longer give out room keys until replacement keys are available and have changed their procedure for completing safety checks.

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: No. Deceased.
Family/Responsible Party interviewed: No. Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility changed their procedure for safety checks and distribution of room keys.

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

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
	40566	A. BUILDING: _____ B. WING _____	C 04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST LIGHT RESIDENTIAL CARE LLC	801 EAST 84TH STREET BLOOMINGTON, MN 55420

(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: HL405661663C/HL405661220M On April 7, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were two residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL405661663C/HL405661220M, tag identification 730.	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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure specific behavior monitoring was documented in the resident record for one of one resident (R1) with records reviewed. R1 required "monitoring" for behaviors including paranoia, depression, and history of cocaine and cannabis use. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: R1 admitted to licensee for diagnoses including schizophrenia, arthritis, and hypertension. R1's service plan dated May 28, 2024, indicated R1 required assistance with grooming, housekeeping, and laundry. The service plan indicated R1 required behavior management three times daily due to depression, anxiety, paranoia, agitation, and repetitive behavior. R1's care plan date January 2, 2025, indicated R1 had a history of using cocaine and cannabis.	0 730		

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0 730	Continued From page 3 The care plan indicated he was "high risk" for relapse and required supervision and redirection. The care plan indicated R1 had "severe" anxiety and depression. The care plan indicated staff members were available for redirection and supervision twenty-four hours per day. R1's individual abuse prevention plan (IAPP) dated January 7, 2025, indicated R1 used cocaine and cannabis. R1 went to "group" but was high risk for relapse and needed supervision and redirection. The IAPP indicated R1 was at risk to abuse others, and at risk for abuse by others because of his aggression and paranoia. The IAPP indicated staff would be available twenty-four hours a day to provide supervision and re-direction. Service delivery records dated January 1, 2025, through April 7, 2025, failed to identify what R1's response was to behavior monitoring. Service delivery records indicated staff were to manage agitation, anxiety, repetitive behavior, depression, and paranoia every shift. The licensee's documentation only indicated the time staff documented these services. R1's record lacked documentation to indicate what staff observed with the behavior monitoring each shift, if the behavior was present, or if R1 required interventions to manage behaviors. On April 7, 2025, at 8:58 a.m., registered nurse (RN)-A said staff use an electronic system for documentation (RTask). Staff members document completion of services in the electronic system. On April 7, 2025, at 12:48 p.m., RN-A said R1 was paranoid and believed insects were coming	0 730		

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0 730	Continued From page 4 in/out of his room. RN-A said they called emergency services (911) because of this paranoia. RN-A said medical providers provided medication for him to manage his behaviors. On April 14, 2025, at 4:08 p.m., the surveyor requested the licensee's policy regarding documentation of services. No policy was provided. The licensee's policy titled, Service Plan, dated August 1, 2021, indicated the licensee would implement and provide all services required by the service plan. Time period for correction: Twenty-One (21) days	0 730		