DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL247802723M
Compliance #: HL247802176C

Date Concluded: July 2, 2024

Name, Address, and County of Licensee Investigated:
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, BSN, 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 a resident when they failed to provide adequate supervision and monitoring. The resident was sexually assaulted by another resident and used methamphetamine (illegal potent stimulant) at least two times a week when she resided at the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. Although the resident denied being sexually assaulted, the resident performed sexual favors for a male resident in his room in exchange for illegal drugs. The facility allowed the resident to enter and lock herself in male residents' rooms, take illegal drugs, and on one occasion the resident overdosed on Fentanyl (synthetic opioid narcotic) in a male resident's room. Despite awareness of the resident's risky behaviors, which also included taking illegal drugs in the community, the facility failed to implement interventions for the resident's safety and provide the resident with appropriate supervision in the facility and in the community.

The investigators conducted interviews with facility staff members, including licensed and unlicensed staff. The investigator contacted law enforcement, the resident's licensed healthcare professionals and a family member. The investigation included review of resident records, facility records, the resident's hospital record, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. The investigator observed resident cares during the on-site investigation.

The resident resided in an assisted living facility for eight months following a discharge from a drug treatment center. The resident's diagnoses included polysubstance abuse, borderline personality disorder, anxiety, and post-traumatic stress disorder. The resident required assistance with behaviors including spending extended periods of time in male resident rooms, using illegal drugs while out in the community, and dealing with emotions when the resident discussed past traumas of sexual abuse, unstable housing, and drugs. The resident had periods of disorientation, forgetfulness, and poor judgement. Staff were directed to provide the resident one-to-one interaction, support, and redirection. In addition, staff were directed to notify the registered nurse if the resident experienced any physical or psychological change that required treatment. The goals for the resident were to maintain the resident's mental and physical stability. The resident was alert, oriented, and walked independently.

The resident's record indicated the resident told her guardian and licensed health professional she used methamphetamines twice a week in the facility since her admission eight months ago. The resident stated another male resident provided the resident with methamphetamine and stated he also sexually assaulted her.

The resident's progress notes indicated multiple times facility staff were aware the resident was in the male resident room for hours and failed to consistently intervene.

The resident's incident report indicated one morning at 4:00 a.m., the resident returned to the facility after being out in the community for several hours unsupervised. The resident entered the male resident's room, closed, and locked his door. Two hours later, staff found the resident lying on the floor in the male resident's room. Staff encouraged the resident to go to her room, but the resident refused so staff placed a pillow under her head and covered the resident with a comforter. Hours later, staff found the resident drowsy and sweaty. Staff notified the facility registered nurse who assessed the resident and arranged for emergency medical services to transport the resident for an evaluation at a hospital.

The resident's hospital record indicated the resident tested positive for Fentanyl.

During an interview, a staff member stated the resident would go into a male resident room and take illegal drugs. The staff member stated the resident overdosed in the male resident room and overdosed many times while in the community. The staff member stated residents

shared drugs, stating sometimes the staff member found a white powdery substance or would see residents buying drugs from people parked in cars outside the facility.

During an interview, the registered nurse stated safety checks were increased and documented when a resident was "high" on drugs or intoxicated but stated staff were not always consistent with documenting the safety checks. The registered nurse stated the resident liked to follow men and would meet men at the local convenience store. The registered nurse stated the facility was responsible to ensure the residents' mental and physical health in the facility. The registered nurse stated some of the residents had drug issues but had a right to come and go out of the facility stating, "We are not a locked unit".

During an interview, the resident stated another male resident gave her methamphetamine laced with Fentanyl. The resident stated the male resident made her perform oral sex in exchange for drugs, stating she was afraid of him. The resident stated other male residents forced themselves on her as well. The resident stated, "I didn't want to discharge from the facility because I was addicted to drugs" and the drugs were available at the facility. The resident stated the facility was aware she and other residents were doing methamphetamine in the facility and out in the community.

During an interview, the resident's guardian stated the resident was traumatized while she resided in the facility. The legal guardian stated the resident told her about the male resident giving her methamphetamine all the time, stating the resident almost died after she overdosed in his room after he gave her methamphetamine laced with Fentanyl. The resident's guardian requested facility staff accompany the resident when out on walks and not allow the resident to leave the facility after 7:00 p.m. The guardian stated in response to the request, facility management said they could not do anything because the facility was not a locked unit.

During an interview, the resident's family member stated she wondered what kind of supervision the resident received at the facility. The family member stated facility leadership was detached from what was going on in the facility stating, "those people (staff), really didn't know what they were doing." The family member stated the resident was happier since she left the facility.

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: Not applicable.

Action taken by facility:
The facility called 911 after the resident overdosed in another resident's room.

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
Crystal City Attorney
Crystal Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	**5724 BASS LAKE ROAD CRYSTAL, MN 55429**

(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: #HL247802176C/#HL247802723M #HL247809922C/#HL247802004M On May 14, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order was issued. At the time of the complaint investigation, there were 10 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL247802176C/#HL247802723M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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02360	Continued From page 1	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 four residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was 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.	