

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL253722902M
Compliance #: HL253724805C

Date Concluded: September 8, 2023

Name, Address, and County of Licensee

Investigated:

Restart Inc
4525 Aldrich Ave. South
Minneapolis, MN 55419
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 a resident requested medications for a leave of absence and did not return to the facility.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide adequate supervision and services to ensure the resident's health and safety. The resident eloped and was found in jail and charged with burglary.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement, the resident's case manager, and the resident's guardian. The investigation included review of the resident's medical record, police reports, personnel files, and facility policies and procedures. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury (TBI), major depressive disorder, and chemical dependency. The resident's service plan included assistance with behavior management, medication administration, and safety checks. The resident's assessment indicated the resident had cognitive difficulties with decision making, a history of elopements, did not have community orientation skills.

Review of the resident's medical record indicated the resident requested staff to provide two days of medications to take with him on a planned two-day leave of absence from the facility. Staff complied with the request and provided the medications to the resident.

On Wednesday, the resident did not return to the facility as planned. However, staff did not report the resident missing and did not contact the resident's case manager, guardian, or facility management, when the resident did not return.

Review of the resident's medication administration record (MAR) indicated the MAR was continually signed out by staff during the resident's time out of the facility as "[the resident] requested meds, LOA [leave of absence] patient took meds with him" despite the resident not being in the facility and staff's awareness of the resident not having these medications available and the medications not being administered.

On Thursday, the resident's case manager called the facility for a scheduled weekly phone call with the resident. However, staff informed the case manager the resident was not available and had been out of the facility since Tuesday. Case management notes indicated when the case worker contacted the facility, staff had not called police to report the resident missing.

Facility staff completed an incident report and contacted police on Thursday, following the phone call with the case manager.

The incident report identified the incident type as an "unauthorized or unexplained absence" and details of the incident identified the resident was "gone" from the facility and missed his medications on Wednesday. The incident report identified the resident's case manager, guardian, and police were notified of the resident's absence.

The police report indicated staff reported the resident missing on Thursday morning. Facility staff told police the resident left the facility on Sunday afternoon and did not return. The police report indicated the resident was found the following day, in the county jail.

Investigative interviews identified the resident had recently started leaving the facility and staying overnight at a friend's apartment, sometimes for days at a time. Staff had been sending the resident's medications with him per his request.

During an interview, the resident's case manager stated the resident got a job without the help of his care team. The resident was managing his job and was taking his medications with him to his job site, so he didn't need to go back to the facility in the middle of the day. The case manager stated the resident left the facility for family visits overnight, but the case manager, nor the guardian, were aware the resident had been taking his medications and staying overnight at a friend's apartment for days at a time. The case manager stated the resident was impulsive and easily drawn into the wrong crowd. The case manager stated when she called the facility for the scheduled weekly call, she learned the resident wasn't at the facility and staff reported the resident had been on a leave of absence for days.

During an interview, the resident's guardian stated she was aware the resident was leaving the facility to go to his job, however, was not aware he was taking his medications with him. The guardian was unaware and had not approved of the resident being out of the facility overnight and unsupervised for multiple days at a time. The guardian stated the day the resident was reported missing to police, the case manager was the one who updated the guardian on the situation.

During an interview, facility management stated the resident admitted to the facility from a locked unit due to substance abuse issues and criminal charges. Facility management indicated the resident was allowed to work in the community and bring medications with him to his jobsite. Facility management indicated at the time of the incident, they were not aware of the length of time the resident was missing and staff should have contacted police immediately.

During an interview, the resident stated he wasn't making the best decisions at the time of the incident, and he decided not to come home for a month or two. The resident stated he went to jail but later returned to 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:

None.

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
Minneapolis City Attorney
Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/10/2023
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NAME OF PROVIDER OR SUPPLIER RESTART INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4525 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55419
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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
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>#HL253724805C/#HL253722902M</p> <p>On July 10, 2023, 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 10 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued/orders are issued for #HL253724805C /#HL253722902M, tag identification 2320, 2360.</p>	0 000	<p>The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators' findings is the Time Period for Correction.</p> <p>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys and/or complaint investigations.</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>	

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

Minnesota Department of Health

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
02320 SS=G	<p>144G.91 Subd. 4 (b) Appropriate care and services</p> <p>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident (R1) received health care services and supervision when the R1 eloped from the facility resulting in R1 booked into jail for burglary and self admitted to be under the influence of recreational drugs.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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</p>	02320		

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02320	<p>Continued From page 2</p> <p>R1 admitted to the licensee on December 6, 2021, due to diagnoses that included TBI (traumatic brain injury) due to a MVA (motor vehicle accident), major depressive disorder, and chemical dependency..</p> <p>R1's service plan undated, indicated R1 received behavior management, medication administration, and safety checks.</p> <p>R1's individual abuse prevention plan (IAPP) dated November 29, 2021, indicated R1 was likely to seek or cooperate in abusive situations. IAPP indicated R1 lacked community orientation skills.</p> <p>R1's assessment dated May 8, 2022, indicated staff administer medications and self-medication is not applicable. R1's assessment indicated R1 was an elopement risk and had current symptoms of mental health conditions.</p> <p>R1's coordinated services and supports plan dated October 29, 2021, indicated R1 had a court appointed guardian to assist in health and safety decision making.</p> <p>R1's medication administration record (MAR) for August 2022, indicated R1 took the medications on a leave of absence August 8, 2022, to August 11, 2022. August 11, 2022, indicated R1 was no longer at the facility.</p> <p>An incident report dated August 11, 2022, indicated R1 was gone from the facility on August 10, 2022, without medications. R1 did not return to the facility after "independent" time away. The incident report indicated R1 had eloped from a prior facility.</p>	02320		

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02320	<p>Continued From page 3</p> <p>The police report dated August 11, 2022, indicated staff notified the police of a missing person. R1 had left the facility on August 7, 2022. Staff told the police R1 might be in jail for riding in a stolen vehicle.</p> <p>Case notes dated August 12, 2022, indicated R1 left a voicemail stating he was in the wrong place at the wrong time. R1 was charged with burglary and in jail.</p> <p>R1's medical record lacked an updated IAPP. Progress notes for R1 for the timeframe of the incident were not available.</p> <p>During an interview on July 18, 2023, case manager (CM)-C stated R1 got a job on his own without the help of the care team. R1 took the bus to and from work. CM-C stated R1 was approved to take his medications with to work so he didn't need to go back and forth to the facility. R1 had approval to stay overnights with family. CM-C, or the family were not aware R1 was leaving the facility for overnight to stay at a friend's house. CM-C stated R1 was impulsive and becomes friends with the wrong crowds easily. CM-C stated R1 admitted to substance abuse while he was out of the facility.</p> <p>During an interview July 27, 2023, guardian (G)-E stated she was not aware nor did not give approval for R1 to take his medications outside of the facility. G-E stated she thought the licensee was administering R1's medications. G-E was not aware R1 was sleeping at a friend's house overnights and R1 did not have approval to sleep overnight at a friend's house.</p> <p>During an interview July 26, 2023, registered nurse (RN)-B stated when completing an</p>	02320		

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02320	<p>Continued From page 4</p> <p>assessment and a resident was unable to be in the community unsupervised RN-B stated she would document her findings, but she can't physically make them stay at the facility.</p> <p>During an interview July 27, 2023, licensed assisted living director (LALD)-A stated R1 was admitted from a locked unit because of R1's history of substance abuse. LALD-A stated R1 was assessed for community safety on admission and reassessed after 30 days. LALD-A stated R1 had the right to leave the facility. LALD-A stated the licensee can't restrict R1's access to the community. LALD-A stated R1 was assessed for self-administration of medication for administration in the facility not for out on leave of absence. LALD-A stated the medications are R1's and we have to give them to him.</p> <p>The licensee's Missing Client Policy dated July 15, 2021, indicated when a resident is believed to be missing the staff determine if the resident is away from the building and/or with family, friends, or a staff escort and check with other staff on duty, communication logs, sign out log and contact family. If unable to locate the resident 911 will be called.</p> <p>The licensee's undated Minnesota Bill of Rights for Assisted Living Residents indicated residents have the right to enter and leave the facility as they choose this right can be restricted consistent with the resident's service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02320		

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02360	Continued From page 5	02360		
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 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(s) 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		