Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307426303M
Compliance #: HL307421960C

Date Concluded: October 31, 2023

Name, Address, and County of Licensee Investigated:
Brandon's Assisted Living
305 Central Avenue South
Brandon, MN, 56315
Douglas County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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):
An alleged perpetrator (AP), facility staff, neglected a resident when the AP smoked methamphetamine (illegal stimulant) with the resident in the resident's room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP admitted to smoking methamphetamine with the resident and bringing drug paraphernalia (used to smoke methamphetamine) into the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the AP. The investigator contacted law enforcement and reviewed the law enforcement report. The investigation included review of the resident's record, facility's policy and procedures, facility's investigation into the incident, and personnel files. Also, the investigator observed the facility, the resident, and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included peripheral vascular disease (reduced circulation), chronic obstructive pulmonary disease (COPD), dementia, high blood pressure, anxiety, and depression. The resident's services included assistance with medication administration, bathing, cues for dressing and grooming. The resident's assessment indicated the resident was alert, oriented, forgetful, and was able to summon for staff assistance.

Review of the facility's internal investigation and incident report indicated when conducting wellness checks, unlicensed personnel (ULP) overheard talking from the resident's room. The ULP walked into the resident's room and observed the AP smoking methamphetamine with the resident. The ULP contacted law enforcement. When interviewed by facility staff, the resident stated the methamphetamine belonged to the AP. The AP stated the methamphetamine belonged to the resident.

During an interview, the unlicensed personnel stated while doing room checks she witnessed the AP and the resident smoking methamphetamine from a pipe in the resident's room. The ULP stated she contacted law enforcement.

During an interview, leadership stated the AP stayed after her scheduled shift to assist the resident with setting up a dresser. When the unlicensed personnel conducted scheduled rounds, the ULP witnessed the AP in the resident's room smoking methamphetamine with the resident. Leadership stated law enforcement was called. Leadership stated the AP admitted to smoking methamphetamine with the resident. Leadership stated this type of incident had not occurred at the facility before.

During an interview, the AP stated one day, the resident told the AP to stop by her room later to smoke methamphetamine. After the resident approached her, the AP said she went out and bought drug paraphernalia. The AP said she brought the drug paraphernalia into the facility to the resident's room to use with the resident. The AP stated while off shift, the AP went into the resident's room because the resident wanted to smoke methamphetamine. The AP stated the methamphetamine smoked was not the AP's. The AP stated the facility had a policy in place that methamphetamine and drug use were not allowed in the facility.

The AP's personnel record indicated the AP received the employee handbook which included the facility's drug and alcohol policy which indicated a violation of policy when any employee used illegal drugs or engaged in the illegal use of drugs on or off the job.

Review of the law enforcement report indicated the AP confirmed she smoked methamphetamine with the resident and confirmed she brought drug paraphernalia into the resident's room to smoke methamphetamine. The AP was arrested and charged with a gross misdemeanor. The report was sent to the prosecutor for review.

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: No. Responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility called law enforcement. The AP is no longer employed by the facility.

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.

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
Douglas County Attorney
Brandon City Attorney
Brandon Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30742	A. BUILDING: _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON'S ASSISTED LIVING	305 CENTRAL AVENUE SOUTH BRANDON, MN 56315

(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 1144G.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: #HL307421960C/#HL307426303M On September 19, 2023, 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 8 residents receiving services under the provider's Assisted Living license. The following correction order is issued issued for #HL307421960C/#HL307426303M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff 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	No plan of correction is required for this tag.	