Protecting, Maintaining and Improving the Health of All Minnesotans

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State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333027804M
Compliance #: HL333024611C

Date Concluded: March 4, 2024

Name, Address, and County of Licensee Investigated:
Assurant Care Homes LLC
2750 112TH Lane Northwest
Coon Rapids, MN 55433
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 the resident when the facility failed to supervise the resident. The resident was found dead.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided appropriate supervision of the resident and provided interventions for the resident's safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, death record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the staff's supervision of the residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and bipolar disorder. The resident's service plan included assistance with medication management and administration. The resident's assessment indicated he was independent with activities of daily living and had an extensive history of mental health concerns and drug use. The resident was under the care of a psychiatrist and had a history of previous drug overdose and suicide attempts.

The resident's medication administration record indicated the resident received the doses of Suboxone (a medication to treat opioid use disorder) as ordered. The resident's service delivery record indicated the resident received monitoring of several mental health conditions each shift.

The facility policy indicated staff are to perform safety checks every morning and every evening.

The resident's progress note indicated at 8:00 a.m., staff observed the resident lying face down in his room. The resident was unresponsive. Staff called emergency medical services (EMS) and EMS staff pronounced the resident deceased at the facility.

The resident's death record indicated the cause of death was the effects of methamphetamines.

During an interview, an unlicensed personnel (ULP) stated on the day of the resident's death, he saw the resident alive and well two times on the overnight shift prior to his death in the morning. The ULP stated he gave medications to the resident at 11:00 p.m. and again saw the resident walking to the bathroom and returning to his room at 2:00 a.m. The ULP stated the resident was at his baseline and he did not note any concerns when he saw him. The ULP stated he entered the resident's room at 8:00 a.m. to give morning medications and found the resident unresponsive and lying face down on the floor. The ULP then called EMS.

During investigative interviews, multiple staff members stated they had not noted any changes or concern for possible drug use by the resident. The staff stated they never saw any drug paraphernalia in the resident's room or in the facility.

During an interview, the nurse stated the staff would check on the resident frequently since he would sometimes be confused due to his liver disease. The nurse stated they would search the resident's room and facility for any signs of drug use when the resident became confused because they were unsure if it was due to drug use or his liver disease. The nurse stated they never found any signs of possible drug use. The nurse stated the resident received suboxone to help with drug cravings. The nurse stated the resident had visited with a new girlfriend outside of the facility the day before he died, and he possibly obtained drugs at that time.

During an interview, a family member stated the resident had a severe drug use history prior to moving to the facility. The family member stated the resident was doing better than he ever had since living at the facility. The family member stated she felt the resident was safe at the facility and they staff worked hard to ensure his health and sobriety.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided required monitoring of the resident and called emergency medical services.

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
	33302	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURANT CARE HOMES LLC	2750 112TH LANE NW COON RAPIDS, MN 55433

(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 February 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL333027804M/HL333024611C. No correction orders are issued.	0 000		