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 #: HL335517584M
Compliance #: HL335514140C

Date Concluded: April 1, 2024

Name, Address, and County of Licensee Investigated:
Caring Nurses LLC
7601 Regent Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, 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 staff failed to provide supervision and the resident took an unprescribed drug resulting in her death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's plan of care and facility policies and procedures were followed at the time the incident occurred. Facility staff immediately contacted 911 after they found the resident unresponsive.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator also contacted the resident's case worker and law enforcement. The investigation included review of the resident's medical records, employee training records, and facility documentation including policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included hypotension (low blood pressure), bradycardia (slow heart rate), schizophrenia, and a history of substance abuse. The resident's service plan included for staff to complete two safety checks per day. The resident's assessment indicated the resident was independent with bathing, personal hygiene, dressing, and eating.

Facility documentation indicated staff last saw the resident around 7:45 p.m. visiting with another resident (Resident #2) in their room. Around 8:07 p.m. staff returned to administer the resident's evening medication and found the resident unresponsive in Resident #2's wheelchair. Staff immediately contacted 911 for medical assistance.

The police report indicated that police and paramedics initiated life saving measures upon their arrival to the facility; however, the attempts were unsuccessful and the resident was pronounced dead. The police report indicated illegal drug paraphernalia was found in the personal belongings of Resident #2.

During an interview with facility administration, they stated they were aware of the resident's prior history of illegal drug use but were not aware of any drug use during the resident's stay at the facility.

During an interview with the resident's family, the family stated the resident was under commitment and they had minimal contact with the resident; however, voiced frustration over not being able to obtain further information from the facility surrounding this incident.

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:
Facility staff immediately contacted 911 for assistance.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33551	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7601 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443

(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 March 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL335514140C/#HL335517584M. No correction orders are issued.	0 000		

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