Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336084246M
Compliance #: HL336087184C

Date Concluded: August 23, 2023

Name, Address, and County of Licensee Investigated:
JMKay Healthcare Services
2318 55th Avenue North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 staff failed to check on the intoxicated resident, and a staff discovered the resident deceased the next morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although the facility established planned interventions and trained staff regarding the resident's alcohol use, the facility failed to ensure staff implemented interventions to ensure the safety and well-being of the resident. Staff failed to conduct face-to-face observations of the resident during hourly safety checks, failed to monitor the resident's alcohol consumption per the facility intervention strategies, and failed to consistently notify the nurse when the resident was intoxicated. Several staff failed to monitor the intoxicated resident for at least nine hours prior to finding the resident deceased.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's community case management team supervisor. The investigation included review of law enforcement reports and medical examiner records. The investigator did not observe the facility, as they had no current residents or staff working at the facility at the time of the investigation.

The resident lived in an assisted living facility. The resident's diagnoses included schizoaffective disorder, diabetes, and history of alcohol abuse. The resident's service plan included assistance with blood glucose monitoring, insulin administration, medication administration, housekeeping, laundry, and meals. The resident's nursing assessment indicated the resident used substances due to inadequate coping skills and the facility maintained a "firm expectation" that the resident would attend recovery support and therapy groups regularly. The resident's record indicated he refused to participate in recovery.

The facility created a plan with interventions for nurses and unlicensed staff. The facility reviewed the plan quarterly with no changes. The nurse provided education to staff regarding alcohol abuse, informing a nurse of medical conditions, prevention of alcohol abuse, and recognition of signs of intoxication. The nurse completed seven alcohol screening questionnaires, which all had the same information. The staff interventions included observation and documentation of hourly resident safety checks, providing assistance if the resident needed, and calling 911 if the resident was intoxicated, which staff did at least three times. The plan directed staff to document hourly safety checks but did not indicate if the safety check required face to face observation.

A police report indicated one morning a facility staff called 911 to report an incident of the resident not breathing. The report indicated when the officers arrived, they determined the resident was deceased, and had been for several hours.

During an interview, a staff member stated he worked the night shift prior to the incident. The staff member stated he did not directly observe the resident on hourly safety checks on the night shift, as staff were directed not to disturb the resident's sleep. The staff member stated he listened outside of the resident's door for snoring to verify the resident was okay. The staff member stated he observed the resident once during his 12-hour night shift when the resident, who appeared intoxicated, used the bathroom around midnight. The staff member did not contact the nurse about the resident's intoxication.

During an interview, another staff member stated she worked with the resident the day before the incident and documented at lunchtime the resident was intoxicated. The staff member did not notify the nurse about the resident's intoxication. The staff member stated she arrived at work on the day of the incident but did not check on the resident for an hour or so. The staff member stated she went to the resident's room to give him morning medications. The resident was found lying on the floor by his door, and the staff saw he was not breathing. The staff

member stated she left a message for the nurse and called 911 but she did not touch the resident.

During an interview, a nurse stated staff were expected to conduct face to face hourly safety checks and call 911 if staff observed the resident intoxicated. The nurse stated the practice for conducting hourly checks at night was to listen outside the resident's door when he was sleeping. The nurse stated staff did not inform him of the resident's intoxication the day before the incident.

During investigative interviews, multiple staff members stated the resident drank alcohol every day and the facility plan for the resident was to call 911 when he was "really drunk". The staff members could not provide a description of "really drunk" but stated they would contact the nurse if they were concerned.

During an interview, a community case worker for the resident stated the facility had ensured they could care for the resident physically and mentally but did not. The community worker stated the nurse did not assess the resident when he was clearly deteriorating, and the staff had no idea how to help the resident other than to call 911.

During an interview, a family member stated the resident's room was full of empty liquor bottles and the facility did nothing to help the resident. The family member stated the resident was unhappy and used alcohol to quiet his other mental health symptoms. The family member stated they could not understand how anyone could work with the resident every day and not know he was so ill.

The resident's death certificate indicated the cause of death was complications of chronic alcohol abuse including alcoholic ketoacidosis.

In conclusion, neglect is 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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Center City Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33608	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JMKAY HEALTHCARE SERVICES INC	2318 55TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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 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: #HL336087184C/#HL336084246M On August 14, 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 no residents receiving services under the provider's Assisted Living license. The following correction orders are issued for#HL336087184C/#HL336084246M, tag identification 2310 and 2360.	0 000	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.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services for one of one resident (R1) reviewed. The licensee failed to implement an up-to-date individualized service plan following accepted health care standards for R1 who had a history of alcohol abuse. R1 had multiple incidents of drinking alcohol to intoxication and died. The licensee failed to ensure staff completed face to face hourly safety checks, failed to ensure staff notified the nurse when R1 was intoxicated, and failed to direct staff to call 911 if they suspected alcohol intoxication. Staff documented R1's intoxication, failed to notify the registered nurse, failed to conduct face to face monitoring of R1 for nine hours, and staff found R1 deceased. This practice resulted in a level four violation (a violation that results in 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). Findings include: R1 moved into the facility on June 24, 2021, due to diagnoses including schizoaffective disorder, depression, anxiety, high blood pressure, diabetes, alcohol abuse, and obstructive sleep apnea.	02310		

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02310	Continued From page 2 R1's Service Plan dated June 24, 2021, indicated R1 received assistance with medication administration, blood glucose checks, insulin administration, reminders to use continuous positive airway pressure (CPAP) machine at night, housekeeping, laundry, and meals. R1's Intervention Plan for Resident with Alcohol Abuse document dated August 30, 2021, directed staff to conduct hourly wellness checks to ensure the resident's safety, document the hourly checks, provide immediate assistance if needed, and follow the Alcohol policy and procedure. The plan further directed staff to ensure R1's safety, minimize withdrawal symptoms, call 911 when suspected alcohol intoxication and any life-threatening issues, monitor R1's physical health regularly, and notify the registered nurse of any changes in R1's health. The facility Meeting Agenda document dated September 9, 2021, indicated registered nurse (RN)-F provided education to staff on alcohol/substance abuse and keeping nurses informed of client's behaviors and medical conditions. Staff in attendance included unlicensed personnel (ULP)-C and ULP-D. Minnesota Adult Abuse Reporting Center report dated September 29, 2021, indicated registered nurse (RN)-F expressed concern regarding R1's self-neglect due to daily consumption of alcohol. R1's incident report dated January 24, 2022, indicated staff observed R1 vomiting, the registered nurse was informed, and staff took vital signs. R1's medical record contained no nursing assessment after the incident or documentation as to whether alcohol was a	02310		

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02310	Continued From page 3 factor. R1's nursing assessment dated March 23, 2022, indicated a staff observed R1 intoxicated and called 911 on March 11, 2022. The assessment indicated the nurse "encouraged [R1] to cut down on alcohol." R1's record contained no incident report, or documentation of the March 11, 2022, incident. R1's incident report dated May 8, 2022, indicated R1 had an unwitnessed fall, the nurse was informed, and staff took vital signs. R1's record contained no nursing assessment after the incident or whether alcohol was involved. R1's incident report dated August 16, 2022, indicated staff observed R1 drunk. The staff called 911, R1 went to the hospital, and staff found an undocumented number of liquor bottles in R1's room. R1's nursing assessment dated August 17, 2022, indicated a plan to send R1 "to detox as discussed." R1's record contained no documentation of whether R1 went to detox. R1's individual abuse prevention plan (IAPP) dated September 23, 2022, indicated staff would monitor R1 and report if staff suspected R1 was intoxicated or if R1 was drinking in his room. Staff were directed to provide regular checks and ensure hand sanitizer was locked in office due to R1 abusing. The IAPP directed staff to report any health concern to the RN/LPN who would assess and communicate with the primary care. R1's nursing assessment dated September 23, 2022, indicated R1 had a substance abuse problem with a long-term goal of treatment, and	02310		

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02310	Continued From page 4 nursing interventions to include "review definition of drug dependence and categories of symptoms, discuss [R1's] current life situation and impact of substance abuse, provide information regarding effects of addiction, and maintain firm expectation that [R1] attend recovery support and therapy groups regularly." The Staff Meeting Agenda document dated October 6, 2022, indicated RN-F provided education regarding alcohol abuse, prevention, recognition of symptoms of intoxication, and staff interventions. Staff in attendance included ULP-C and ULP-D. R1's incident report dated November 4, 2022, indicated unnamed staff observed R1 "very drunk, not stable and aggressive, struggling to breathe, fell to floor," and staff called 911. The report indicated staff found an undocumented number of liquor bottles which they placed in the nursing office. R1's nursing assessment dated November 5, 2022, indicated R1 spent the previous night in the hospital due to excessive intoxication and struggling to breathe. The assessment indicated staff would report changes in R1's health status and continue to provide redirection with inappropriate behaviors at home and in the community. The Staff Meeting Agenda document dated November 17, 2022, indicated RN-F provided staff education on alcohol/substance abuse, prevention, recognizing triggers, symptoms of alcohol intoxication, and interventions. Staff in attendance included ULP-C and ULP-D. R1's progress note dated December 7, 2022,	02310		

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02310	Continued From page 5 8:00 a.m.-8:00 p.m., indicated "The new medication, Diazepam, scheduled for four days was discontinued because [R1] was drunk, under the influence of liquor." R1's record contained no nursing assessment or incident report. R1's progress note dated December 11, 2022, 8:00 a.m.-8:00 p.m., written by ULP-C, indicated "After lunch staff noticed [R1] drunk. Staff told him to stop drinking, that it is not good for health," and he replied, "I can't stop drinking." "Safety check done, all medications and insulin administered as scheduled." R1's record contained no documentation that ULP-C called a nurse. R1's Client Hourly Check Log document dated December 11, 2022, indicated ULP-D checked on R1 and noted R1 to be "ok" every hour from 8:00 p.m. December 11, 2022, to 7:00 a.m. December 12, 2022. R1's incident report dated December 12, 2022, (untimed) indicated ULP-C entered R1's room at approximately 9:05 a.m. and observed R1 face down on the floor, not breathing. The report indicated ULP-C called 911, the nurse (RN-F), and a supervisor (ULP-B). A law enforcement report dated December 12, 2022, indicated officers entered R1's room at 9:31 a.m. and observed R1 lying face down on the floor next to the doorway. The report indicated an officer touched R1 and found him to be cold and stiff (as he "had entered rigor mortis") and appeared to have been "deceased for hours". The report indicated ULP-C told an officer she observed R1 intoxicated the night before (December 11, 2022) when she left work at 8:00 p.m. ULP-C told the officer she did not check R1	02310		

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02310	Continued From page 6 until between 9:00 a.m. and 9:30 a.m. on December 12, 2022. A medical examiner report dated December 12, 2022, (untimed) documented observation of multiple alcohol bottles (empty and full) in R1's room and refrigerator, along with several containers of hand sanitizer. The report indicated R1's blood alcohol level was .353 grams per milliliter (g/ml) and cause of death was complications of chronic ethanol abuse, including alcoholic ketoacidosis. During an interview on August 14, 2023, at 2:48 p.m. ULP-B stated R1 drank nearly every day and had bottles of alcohol in his room which staff would remove. ULP-B stated staff tried to prevent R1 from drinking, however, ULP-B could not identify how staff tried to prevent R1 drinking. ULP-B stated the staff would check on R1 when he was intoxicated to see if he was breathing, but there was nothing they could do except call 911 if he was "really bad." ULP-B could not identify what signs or symptoms they considered "really bad." During an interview on August 15, 2023, at 8:15 a.m. ULP-C stated it was company protocol to check on residents every hour, but staff did not go into R1's room if he was sleeping. ULP-C stated she last saw R1 on December 11, 2022, when she left work at 8:00 p.m. ULP-C stated she did not go into R1's room at 8:00 a.m. when she arrived at work on December 12, 2022, but waited until 9:00 a.m. to go in to his room to give him his morning medications. ULP-C stated when she opened R1's door, she observed R1 on the floor, so she did not touch him, left a message for RN-F, and called 911. During an interview on August 15, 2023, at 8:33	02310		

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02310	Continued From page 7 a.m., ULP-D stated R1 was intoxicated the night before his death and refused his 8:00 p.m. medications. ULP-D stated he last saw R1 around 12:00 a.m. on December 12, 2022, when R1 came out of his room to use the restroom, and R1 was visibly intoxicated. ULP-D stated he did not go into R1's room for hourly safety checks but instead listened for R1's snoring through the door. ULP-D stated the staff were directed to call 911 if R1 had an "issue with drinking" so emergency responders would take R1 to the hospital. During an interview on August 15, 2023, case manager (CM)-E stated R1 had intensive needs related to alcohol use that the licensee did not provide, such as ensuring he went to provider appointments, assessing him medically, monitoring, and providing oversight of medications. CM-E stated the licensee did not understand how his substance abuse affected R1 medically. CM-E stated she was not a medical professional but had observed R1's yellow skin color and yellow eyes, noting that the nurse had no concerns and did not assess R1 when CM-E brought it to the nurse's attention (on an unknown date). CM-E stated the licensee assured her team they (the facility) would be able to provide R1 with the services he required, but they did not. During an interview on August 15, 2023, RN-F stated staff were directed to go into R1's room for hourly safety checks to verify face to face that R1 was breathing. RN-F stated the staff practice, however, was to listen outside R1's door for snoring if R1 was asleep. RN-F stated he never witnessed R1 drink alcohol, did not recall a day where R1 was "really, really drunk", but stated the staff were directed to call 911 to send R1 to the hospital if R1 was "really drunk." RN-F stated	02310		

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02310	Continued From page 8 staff did not call to inform him that R1 was intoxicated on December 11, 2022. The facility Alcoholic Beverages policy dated February 21, 2023, indicated the facility kept all alcoholic beverages in the locked nursing office and required a safety assessment and a physician's order to allow resident consumption. The policy indicated the facility would not take responsibility for any incidents or accidents resulting from nonphysician-ordered alcohol consumption. The Supervision/Safety Checks policy dated Jun 17, 2023, indicated all residents would receive regular safety checks throughout the day and night. The policy indicated the nighttime safety checks should be frequent enough to ensure resident safety without causing unnecessary disruptions to sleep. The Comprehensive Nursing Assessment policy dated August 1, 2023, indicated a registered nurse would conduct a comprehensive assessment for all residents to determine services required and develop an individualized care plan for staff to implement. The Service Plan policy dated August 1, 2023, indicated a resident service plan would be developed based on the assessed needs of the resident and revised based on reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		

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02360	Continued From page 9	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 one resident(s) reviewed (R1) was free from maltreatment. Findings include: 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.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	