Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351344084M
Compliance #: HL351346895C

Date Concluded: August 10, 2023

Name, Address, and County of Licensee Investigated:
Topcare Health Services
8936 Douglas Drive North
Brooklyn Park, MN 55445
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

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 they failed to supervise the resident, he obtained illicit drugs, overdosed, and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided appropriate supervision of the resident who did not require one to one staffing while in the facility but did have one to one staffing while in the community. The resident had no history of drug abuse, and it could not be determined from whom or when the resident obtained the illicit drugs.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of law enforcement reports, medical examiner reports, medical records, facility documents, incident reports, policies, and procedures related to assessments, emergency

response, service plans, supervision, and maltreatment of vulnerable adults. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility. The resident's diagnoses included intellectual disability, autism spectrum disorder, and post-traumatic stress disorder. The resident's service plan included assistance with medication administration, assistance with behavior management (anxiety, impaired communication, agitation, aggression, and isolation), reminders for personal cares, meal preparation, housekeeping, laundry, and supervision/transportation for activities/outings (related to intellectual functioning). The resident's assessment indicated the resident had mental health vulnerabilities and no history of drug abuse.

A progress note indicated one evening the resident shouted at staff and refused his medication, which was unusual for the resident. The note indicated the resident aggressively approached a staff, and the usual staff interventions were ineffective. The staff called the nurse to the facility, told other residents to remain in their rooms, and took one resident and their family member outside. The note indicated when the nurse arrived the resident fell to the floor and appeared to have a seizure.

During an interview, the nurse stated she had a good rapport with the resident, so when staff notified her of the unusual aggression, she immediately drove to the facility. The nurse stated when she arrived, she assessed the resident, who was on the floor. The resident was awake and had seizure-like movements of his upper body. The nurse stated the resident had a strong pulse but began to have difficulty breathing and then stopped breathing. The nurse stated she called 911, began cardiopulmonary resuscitation, and the paramedics took over when they arrived.

A police report indicated within minutes of the paramedics arriving the resident went into cardiac arrest. The report indicated despite lifesaving efforts the resident passed away. The report indicated they called the medical examiner to the facility. The police looked in the resident's bedroom and found no evidence of external factors that may have contributed to the incident. The report indicated an officer reviewed surveillance video which provided no additional evidence.

The medical examiner report indicated the residents toxicology report indicated the resident died from acute methamphetamine intoxication.

During an interview, a county worker stated the county monitored the resident and he had done well at the facility over several years. The worker stated the county initially paid the facility to provide one to one staff supervision of the resident, but after several years, phased it out, as he had done so well.

During investigative interviews, multiple staff members stated the resident had no history of using illicit drugs. The staff stated the resident liked to play video games, smoke cigarettes, and

stay in his room. The staff stated the resident did not interact with his peers as he did not feel comfortable with others in his personal space.

During an interview, a family member stated the resident had been placed on one-to-one staff supervision to ensure he did not elope. The family member stated the resident had one incident prior to admission to the facility, where marijuana was found in his system, but the resident was not known to use illicit drugs. The family member stated he was surprised when he learned of the resident's cause of death. The family member stated the resident was vulnerable and suspected some other resident gave him the drugs but had no evidence.

In conclusion, neglect is 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.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility provided staff with education on recognition of symptoms and interventions.

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
	35134	A. BUILDING: _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPCARE HEALTH SERVICES LLC	8936 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55445

(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 August 7, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL351346895C/#HL351344084M. No correction orders are issued.	0 000		