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 #: HL352945421M **Date Concluded:** December 31,2024
Compliance #: HL352947449C

Name, Address, and County of Licensee Investigated:
Souriyathay Housing with Services
6231 Sunny Lane North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Michele Larson, RN
Special Investigator

REQUEST FOR RECONSIDERATION RECEIVED

Finding: Substantiated, facility 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):
The facility neglected a resident when they failed to adequately monitor a resident's well-being by performing safety checks and scheduled services. Facility staff did not enter the resident's room for multiple days. The resident was found deceased in his room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The days leading up to the resident's death, facility staff failed to physically check on the resident to ensure he was okay, or ensure the resident ate, took his prescribed medications, or received other scheduled services. The resident was in his room for days, not answering or responding to staff verbal requests or staff knocking on the resident door. Those actions were a deviation from the resident's regular routine of responding to staff's knocks, or coming out of his room to eat, toilet, and take his medications.

The investigator conducted interviews with facility staff members, including administrative staff, unlicensed staff. The investigator interviewed the resident's family member. The investigation included review of the resident's facility record, death record, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed direct staff and resident interactions while onsite at the facility.

The resident resided in an assisted living. The resident's diagnoses included a stroke, right-sided paralysis, diabetes, chronic kidney disease, and high blood pressure. The resident was alert, oriented and able to make his needs known. The resident required assistance with transfers, meals, bathing, and required supervision and stand-by assistance and a cane with walking due to unsteadiness. The resident was prescribed several medications including insulin and required reminders and assistance with medication administration. The resident was at risk for self-abuse and staff were directed to supervise the resident 24/7 for concerns of self-abuse and report concerns promptly to the nurse.

The resident's scheduled services included daily walking, escorts, mobility assistance, behavior management, medication administration, and housekeeping. Overnight scheduled services included assistance with transfers, escorts, mobility, managing self-injurious behaviors, walking, and exercise. The resident was a "full code," wanting all possible life-saving measures to keep him alive, including cardiopulmonary resuscitation (CPR).

Review of the resident's service delivery record documentation indicated on the seventh day of one month staff documented, the resident was sleeping in his room, and "has not come out from his room and not taking medication."

The next day, staff documented, the resident was "not following primary care orders and kidney specialist recommended referral to treat his illness. As much as we want to care for the resident he is heading in a different direction where he's harming himself."

A day later, staff documented, the resident was currently isolating in his room, appeared to be sleeping and not coming out even once that shift to toilet, eat, take medications, or to do anything else.

The next morning, unlicensed personnel documented, they had not observed the resident that morning and the resident remained in his room. The unlicensed personnel knocked on the resident's door a few times with no response. Unlicensed personnel checked the outside patio door to the resident's room and verbally reminded the resident it was time for his medications, but the resident gave no response. The unlicensed personnel could not hear any noise from the resident's room, notified administration of the resident's status at that time and stated, "will try again at 2:00 p.m." Later that same day and when the resident continued to not respond to staff, leadership instructed unlicensed staff to call emergency services for the resident.

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Review of the police report indicated on the fourth day of not seeing the resident, at 3:50 p.m., police were dispatched to the facility after staff called to report the resident refused to open his door or take his medications. Facility staff reported they thought it was a medical issue since staff had not heard from the resident all day. The resident was pronounced dead on arrival at 4:05 p.m. when first responders arrived at the facility. The police report indicated first responders noticed the resident's door into his room was cracked open and they could see the resident lying on his bed with blood coming from his nose. The resident showed signs of rigor mortis (stiffening of limbs) and lividity (bluish-purple discoloration of skin after death). When questioned by police, the facility gave conflicting information, stating staff last saw the resident at 10:30 p.m. the prior evening when the resident refused his medication and went back to sleep, even though staff documented the resident was not responding to staff requests days before his death. Leadership told police staff could "see" the resident snoring through his bedroom door the night before.

Review of the resident's record indicted the resident was last physically seen alive, provided a meal, or administered his medications the sixth day of that month at 9:53 p.m., four days before first responders found the resident dead in his room. The staff documentation indicated when the resident missed his meals and medications, "the resident never came out of his room."

During an interview, the resident's case manager stated about three months before the resident died, she met with the facility and the resident to discuss the resident's refusal of medications and services. The case manager stated at the end of the meeting the resident agreed with their recommendations and agreed to let staff enter his room to administer his medications.

During an interview, a facility nurse stated staff and other residents were afraid of the resident stating the resident would yell and swear at them. The nurse stated staff completed safety checks for the resident several times a day through communication and contacting the resident. The facility nurse stated he expected staff to notify him whenever the resident refused his medications even one time, stating staff documented "refused" for services and medications when the resident failed to respond to staff knocking on the resident's door. The nurse stated he had directed staff to call 911 if they were unable to talk to the resident through his door, or if the resident did not come out to take his medications. The nurse stated the resident had an appointment with his provider but stated it was scheduled weeks after the resident died.

During an interview, leadership stated the resident's behaviors started one year after he moved into the facility. Leadership stated staff were afraid to go into his room and stated the resident would sometimes sleep all day and come out at night but stated he could be unpredictable. Leadership stated staff would perform safety checks by putting their ears against the resident's wall to listen for his breathing. Leadership stated staff were to call police if the resident did not respond to their yelling. Leadership stated, had the resident took his medications and saw his provider the resident "could have lived."

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During an interview, the resident's family member stated the resident did not like a lot of people. The family member stated the resident was a "really nice guy" most of the time but would have angry outbursts about once a week. The resident's family member stated the resident "wanted to die."

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: No. The resident was deceased at the time of the investigation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action was taken by the facility.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

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cc:

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35294	A. BUILDING: ______ B. WING ______	C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHAY HOUSING WITH SERVICES	**6231 SUNNY LANE BROOKLYN PARK, MN 55428**

(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: #HL352947449C/#HL352945421M On October 22, 2024, 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 five residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL352947449C/#HL352945421M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. 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.	

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

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02310	Continued From page 1	02310		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (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 observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one (R1) resident reviewed. Licensee staff failed to update the licensee's clinical nurse supervisor (CNS)-E or R1's provider when the resident deviated from his normal routine of coming out of his room to eat or have staff administer his medications. For four days before his death, staff failed to administer the resident's medication and provide the resident meals because the resident never came out of his room. In addition, facility staff failed to enter R1's room to physically check on him to ensure R1 was safe and alive. After days of not getting his medications or meals staff updated CNS-E. Over two hours later staff called 911. First responders found R1 dead with lividity (blood pooling in dependent extremities) and rigor mortis (stiffening of the body). 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).	02310		

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02310	Continued From page 2	02310		

The findings include:

R1's record was reviewed. R1 was admitted to the licensee's facility on April 23, 2023. R1's diagnoses included stroke, right-sided paralysis, chronic renal failure, and Type 2 diabetes.

R1's service plan dated December 8, 2023, indicated R1 received assistance with medication assistance, appointment reminders, and transfers.

R1's assessment dated April 14, 2024, indicated R1 required staff assistance with standing, walking, blood sugar checks and bathing for safety purposes. R1 required supervision when eating and transferring. R1 used a cane for mobility due to decreased muscular coordination from a stroke. R1 was verbally and physically aggressive at times.

R1's individual abuse prevention plan (IAPP) dated May 17, 2024, indicated R1 was alert and oriented to person, place, and time. R1 refused to take his medications as prescribed and declined "Ok" checks from staff. Staff were directed to supervise and monitor the resident 24/7 to monitor for concerns of self-abuse and report promptly to the facility nurse. R1 sometimes locked himself in his room. Staff were to call police when R1 refused to talk to staff each shift. Goals included R1 would remain safe in the facility.

R1's service delivery record dated August 2024, indicated R1 received the following scheduled services: Daily walking, escorts, mobility assistance, behavior management, medication administration, and housekeeping. Overnight scheduled services included assistance with

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02310	Continued From page 3	02310		

transfers, escorts, mobility, managing self-injurious behaviors, walking, and exercise. The resident was a "full code," wanting all possible life-saving measures to keep him alive, including cardiopulmonary resuscitation (CPR).

R1's medication administration record (MAR) dated August 2024, indicated R1 was prescribed several medications for high blood pressure and diabetes, including insulin.

Review of R1's service delivery record dated August 2024, indicated on August 7, 2024, during the evening shift staff documented, "DECLINED: He is sleeping in his room," and "He has not come out from his room and not taking medication."

R1's progress note dated August 7, 2024, at 8:59 p.m., indicated "He's been sleeping and hasn't come out of his room." Staff reported they heard a noise from R1's room so staff walked to R1's door and "leaned my ears to listen, I can hear a noise from his room, and it sounds like he's talking in his sleep."

R1's progress note lacked documentation staff physically entered R1's room to ensure R1 was safe.

Another entry note in R1's service delivery record dated August 8, 2024, indicated during the morning shift staff documented, "He's not following primary care orders and kidney specialist recommended referral to treat his illness. As much as we want to care for the resident he is heading in a different direction where he's harming himself."

R1's record lacked documentation the facility

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02310	Continued From page 4	02310		

updated R1's provider or CNS-E about R1's recent refusals.

R1's progress note dated August 9, 2024, at 12:37 p.m., staff documented the following, "R1 is sleeping at the moment and missing lunch/morning and afternoon medication, as staff mention to me when R1 is missed behave or not follow Dr. order or system that Souriyathay Housing with Services put in place it's because he want a revenge on the staff and fellow patients (residents)...yes he actually told our staff that. R1's mental stage is not right...we at this group home tried to get R1 to get anger management or mental treatment but refused."

R1's record lacked documentation R1's provider and CNS-E were updated about R1's refusals.

R1's service delivery record note dated August 9, 2024, indicated during the evening shift staff documented, "R1 is currently isolating in his room appearing sleeping and not coming out even once this shift thus far to toilet, eat, medicate, nor to do anything else."

On August 10, 2024, during the morning shift staff documented, "None. No movement this morning yet. Have not come out of his room. Cannot help transfer resident because he won't come out of his room yet. I tried knocking a few times on the door of resident's room. I also checked the outside window by the patio. I do not hear anything. NO reply if he is okay or not. Announced it was medication time. No reply. NO noise whatsoever. Informed administration. I will try again at 2:00 p.m."

R1's record lacked documentation the facility notified R1's provider about his recent multiple

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02310	Continued From page 5 days of refusing medications, food, toileting, and services. R1's progress note dated August 10, 2024, at 1:21 p.m., unlicensed personnel (ULP)-C documented, "Per CNS-E, "keep trying please." I tried knocking on his door again many times. no reply. Reminded him its medication time. no reply. I said pls [please] just say "yes or no" if you are ok. Nothing. but I think I hear him moved in bed. Very faintly tho, Not very sure." R1's police report dated August 10, 2024, at 3:50 p.m., indicated police were dispatched to the licensee's facility after staff called to report R1 refused to open his door or take his medications. Facility staff reported they "thought" it was a medical issue since staff had not heard from R1 all day. At 4:05 p.m., R1 was pronounced dead by first responders. Fire department staff indicated R1's bedroom door was cracked open when they arrived and observed R1 was "obviously deceased," noting lividity (blood pooling at dependent extremities) and rigor mortis (stiffening of limbs) had already set in and observed blood coming from R1's nose. When questioned by police, owner (OW)-C gave conflicting information, stating staff last saw R1 on August 9, 2024, at 10:30 p.m. when R1 refused his medication and went back to sleep, even though staff documented R1 was not responding to staff requests days before his death. OW-C told police staff could see R1 snoring through his bedroom the night before. Review of R1's record indicated between August 6, 2024, at 7:45 p.m., and August 10, 2024, facility staff failed to administer R1's medications, provide meals, or physically check on R1 to ensure his health and safety.	02310		

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02310	Continued From page 6 During an interview on November 7, 2024, at 8:30 a.m., OW-A stated staff were scared of R1 and afraid to go into his room, stating "We would hear some sounds and lights from R1 coughing and shuffling in his room and if he doesn't come out, we knock on the door, and he would yell out violently every time." OW-A stated staff put their ears to the wall outside R1's room to listen to his breathing and stated if R1 did not respond to their knocks they were instructed to call police. OW-A stated R1 had several scheduled services overnight because he tended to come out of his room when everyone was asleep, stating R1 would sleep all day and come out at night. OW-A stated when R1 would come out to use the bathroom, staff would quickly run up to him to give him his medications and food. During an interview on November 21, 2024, at 9:00 a.m., R1's case manager (CM)-F stated she met with R1 and the facility to discuss the R1's refusal of medications and services about three months before R1 died. CM-F stated at the end of the meeting R1 agreed to let staff enter his room to administer his medications. During an interview on November 20, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-E stated he expected staff to notify him whenever R1 refused his medications even one time, stating staff documented "refused" for medications and services whenever R1 failed to respond to staff knocking on his door. CNS-E stated he directed staff to call 911 if they were unable to talk to R1 through his door, or if R1 did not come out of his room to take his medications. CNS-E stated he scheduled an appointment for R1 to meet with his provider about his refusals but stated R1 died before he could see his	02310		

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02310	Continued From page 7 provider. The licensee's policy titled Administration of Medication, Treatment, and Therapy by Unlicensed Personnel, updated July 31, 2024, indicated medications, treatment, and therapy always need to be administered according to the "6 Rights" (a) right person; (b) right medication, treatment, or therapy; (c) right time; (d) right route (e) right dose; (f) right chart/record to document the medication, treatment, and therapy was taken. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
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 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		

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