Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355464401M
Compliance #: HL355465361C

Date Concluded: October 14, 2024

Name, Address, and County of Licensee Investigated:

Attentive Care
3524 Kyle Avenue North
Crystal, MN 55422
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 to supervise a resident who went into the community, obtained air duster, huffed it to intoxication, and drowned in a nearby lake.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility was aware of the resident's abuse of substances, including air duster, made changes to the resident's level of supervision, service plan, and abuse prevention plan with each incident. The resident was his own decision maker. The medical examiner determined the resident's death was an accident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reached out to the resident's community support persons and family. The investigation included review of the resident record, death

record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident lived in an assisted living facility for approximately a year. The resident's diagnoses included schizophrenia, anxiety, and attention-deficit hyperactivity disorder. The resident's assessment indicated the resident was independent with activities of daily living (ADLs), hygiene, and was his own decision maker. The resident's care plan directed staff to monitor the resident for safety, as he had a history of abuse of street drugs, over the counter medications (Mucinex), and air duster (a canned compressed air containing chemicals used for cleaning electronics) to obtain a euphoric high.

The resident's abuse prevention plans directed staff to have the resident sign out and sign in when leaving the facility for walks. The plan directed staff to monitor the resident's gait and balance upon returning from the community, and if he appeared impaired to obtain vital signs, contact the registered nurse, maintain visual contact minimally every 15 minutes, and contact emergency services if the resident became unresponsive. The nurse updated the plan with each incident of substance abuse, directing staff to proactively address his risks by monitoring for agitation, verbal aggression, and other early warning signs of drug cravings. The facility trained staff on several interventions to implement to distract/redirect the resident and use of non-confrontational de-escalation techniques.

An incident report indicated the resident signed out to go for a walk one evening. The report indicated within an hour, the facility received a call from the resident's girlfriend who expressed concern that the resident was on his way to huff some air duster. The girlfriend requested staff leave the facility and go look for the resident. Staff were unable to leave as they were the only one on site but called the house manager. The report indicated the house manager drove around looking for the resident but did not find him. Several hours later the girlfriend called to report that she had found the resident in a lake, unresponsive. The report indicated the house manager called 911, and responders confirmed the resident's death.

During an interview, a manager stated the resident had successfully completed addiction treatment during his stay at the facility but had returned to old habits. The manager stated the resident would not cooperate with an aftercare plan or therapy. The manager stated the facility did the best they could with the resident.

During an interview, a nurse stated the facility trained staff on the resident's early warning signs of cravings and signs of substance use. The nurse stated staff interventions were in the care plan and staff monitored his vital signs, worked hard to identify triggers, and used non-confrontational de-escalation techniques.

During investigative interviews, several staff members stated the resident was a good person who loved music and talking about his past. The staff stated the resident could not overcome his addiction, even with their support.

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: Attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility updated the resident’s care plan with each incident of chemical abuse and provided staff training on 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
	35546	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTENTIVE CARE	3524 KYLE AVENUE NORTH CRYSTAL, MN 55422

(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 October 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL355465361C/#HL355464401M. No correction orders are issued.	0 000		