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 #: HL35600001M
Compliance #: HL35600002C

Date Concluded: June 21, 2022
Date Amended: November 1, 2023

Name, Address, and County of Licensee Investigated:
Empathy Home Care Inc.
73333 Kentucky Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele R. Larson, Special Investigator

Finding: Substantiated, facility and individual 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.

Allegation(s):
It is alleged: The facility neglected the resident when they failed to provide the resident with adequate supervision and services when the resident had two drug overdoses within five days. The resident overdosed on Fentanyl (narcotic medication) twice within five days. The second overdose caused the resident's death.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. The facility failed to ensure adequate supervision was implemented after the resident's first overdose. The resident's care plan indicated she required safety checks every two hours after the first overdose incident. The updated service plan, which was received after the AP indicated there was no updated service plan, decreased the safety checks and failed to state why. Necessary safety check interventions were not implemented. The facility lacked documentation of written direction how to complete safety checks. The resident's record indicated staff were to notify the AP when they suspected drug use, any behaviors or isolation,

yet the facility allowed staff to come and go a few days after first overdose. Staff witnessed the resident interacting with two different unknown vehicles outside of the facility. The day she died; the resident isolated in her room for hours with no one entering her room to check and see if she was okay. After ten hours without a response from the resident, staff forced the resident's door open and found the resident deceased.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The AP was interviewed. The investigator interviewed the resident's family member. In addition, the investigation included a review of the resident's facility medical record, her hospital and psychiatric record, employee personnel files, and the facility's policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse. The resident required assistance and reminders from facility staff for medication management, behaviors, socialization, meal preparation, housekeeping, laundry, shopping, and bathing.

The resident's incident report indicated at 2:20 a.m., the resident woke up and used the bathroom. An unlicensed personnel (ULP)-1 knocked on the bathroom door; the resident responded she was still in the bathroom and requested ULP-1 to use another bathroom. Fifteen minutes later ULP-1 returned and knocked on the bathroom, calling the resident's name but the resident never responded. At 2:42 a.m., ULP-1 called the AP to inform the resident was not responding to the knocks or her name. The AP told ULP-1 to call 911. At 2:45 a.m., law enforcement and emergency medical services (EMS) arrived and revived the resident using Narcan (medication used for overdose). The resident was transported to a local hospital.

The resident's hospital record indicated EMS found the resident unresponsive, with gasping breathing, when they arrived at the facility. Drug paraphernalia laid on the floor next to the resident. Law enforcement found a pill in the resident's hand which was later identified as an oxycodone (narcotic) pill. The resident told hospital staff she smoked Fentanyl (narcotic) earlier in the evening and took a pill she obtained from a friend. The resident told hospital staff she was "stressed." Hospital staff educated the resident on her opioid overdose and to avoid using street drugs. The resident was discharged back to the facility a few hours later.

The AP updated the resident's care plan after the first incident to have staff perform safety checks every two hours. The care plan indicated staff were to report any signs of drug use, change in behavior, or isolation.

The resident's record lacked documentation the AP verbally told staff to perform hourly checks on the resident as the AP stated in her interview nor a direction on how to perform safety checks.

The resident's service delivery record indicated the resident received services for daily bathing, medication management, oral hygiene, light housekeeping, meals, snacks, facility activities, behavior management, socialization, and weekly shopping.

The resident's service delivery record lacked every two-hour safety check services. Therefore, there was no documentation safety checks were performed.

A supervisor progress note indicated two days after the resident's first overdose, a manager wrote at 1:45 p.m. she watched the resident leave the facility with a man in a black car. The manager never asked where the resident was going or when she would return. Five hours later the resident returned to the facility and went directly to her room. The manager wrote, "no further concerns to report."

A ULP progress note documented by ULP-2 on the night before the resident died, indicated at 7:00 p.m., the resident was out in the living room socializing with staff and other residents. At 8:40 p.m., ULP-2 watched the resident leave the facility to talk with someone in a van parked outside. Moments later the resident returned inside. ULP-2 administered the resident's medications. The resident slept all night until 3:45 a.m. when she woke up, then returned to her room to sleep. ULP-2 documented, "no concerns."

During the onsite interview, the AP told the MDH investigator that the resident’s service plan had not been updated yet. The resident’s care plan was provided to the MDH investigator while on site with the AP. The AP sent the resident’s service plan to the MDH investigator after the interview. According to that service plan, the day before the resident’s overdose, the AP changed the service plan to reflect a change in safety checks, inappropriately decreasing them from every 2 hours to every 6 hours and wrote per the request of the resident.

An incident report completed five days after the resident's first overdose, indicated at 7:00 a.m. and 8:00 a.m., ULP-3 knocked on the resident's door but never opened her door. At 2:00 p.m., ULP-3 broke down the resident's door when the resident did not respond to ULP-3's knocks or her name. ULP-3 found the resident lying on her bed, unresponsive with no pulse. Law enforcement was called to the facility and pronounced the resident dead at the scene.

The resident's death record indicated the cause of death was listed as acute Fentanyl toxicity.

During a recorded interview, the AP stated the facility implemented safety precautions by not allowing the resident to have visitors after her first overdose. The AP stated, the other safety precaution she was thinking about was taking the resident’s “alone time” away. However, later in the interview the AP stated she told staff to perform hourly safety checks for the resident even though the AP stated she believed the resident remained stable after her first overdose. The AP stated the facility still allowed the resident 24 hours alone time in the community. During the interview, the AP stated she did not update the resident's service plan or her individual abuse prevention plan (IAPP) after the resident’s first overdose.

During an interview, ULP-1 stated staff performed hourly safety checks on the resident after the resident's first overdose, stating she physically checked on the resident and stated the resident did not have a problem with the safety checks. ULP-1 stated the AP told staff, we know she is an adult, but when she is sleeping you check in on her.

During an interview, ULP-2 stated she performed safety checks and continually checked on the resident even when the resident was in her room. ULP-2 stated the resident did not mind safety checks and did not indicate the resident posted a do not disturb sign on her door. ULP-2 stated the night before the resident died, she watched the resident leave the facility and get into a vehicle parked outside the facility then return inside moments later. ULP-2 stated she asked the resident if everything was okay. The resident responded she was fine then retreated to her room for the night.

During an interview, ULP-3 stated at 7:00 a.m., the day the resident died, she knocked on the resident's door and listened. ULP-3 stated she was told by night staff not to knock on the resident's door but stated after the resident's first overdose she still knocked. ULP-3 stated she briefly checked on the resident throughout her shift, but never opened the resident's door even after the resident never responded. ULP-3 stated at 2:00 p.m., another ULP arrived with food for the resident. ULP-3 stated she went to the resident's door and knocked again, to wake her up to eat and take her morning medications. After the resident never responded, ULP-3 pushed the door open and found the resident lying on her bed with "stuff" in her hand. ULP-3 stated the resident had no pulse and was cold to the touch. ULP-3 called 911. Law enforcement arrived and pronounced the resident dead.

During an interview, the resident's mental health professional stated the resident had a history of substance abuse and mental health issues, stating the resident overdosed on Tylenol and vodka when she lived independently. The mental health professional stated the resident was not independent and required extra support. The mental health professional stated she did not recall being notified by the facility after the resident's first overdose at the facility, stating she would have remembered if she had. The mental health professional stated they received an email from the AP two days after the resident died informing her of the resident's death. The mental health professional stated, she questioned why people did not check on her if she was up at 4:00 a.m., and then no one checked on her again until 2:00 or 3:00 p.m. The mental health professional stated the facility never notified them the resident was using hard drugs. The mental health professional stated after the resident died, the facility told them the resident was starting to return to her "old behaviors" of going out and leaving the facility. The mental health professional stated, "I thought, why didn't you guys tell us this?"

During an interview, a family member stated the facility was aware of the resident's drug use, stating staff told them they saw the resident getting into a van the night before she died to get drugs but did not do anything to stop the resident. The family member stated they visited the resident the day after first overdose but stated staff never said anything to her about the resident's overdose and never told her the resident was using drugs, stating, "the day I found out my baby was using drugs was the day she died." The family member stated, "I trusted my child with a system that failed her and now I'm stuck with this grief for the rest of my life."

In conclusion, 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:
(a) 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 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 which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. The vulnerable adult is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility talked to staff about the importance of frequent safety checks and monitoring of the resident.

Action taken by the Minnesota Department of Health:
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 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35600	A. BUILDING: ______ B. WING ______	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPATHY HOME CARE INC	**3309 80TH 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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL35600002C/#HL35600001M On April 28, 2022, 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 0 clients receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL35600002C/#HL35600001M, tag identification 620, 630, 1610, 1640, 1650, 2360, 3000.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults for one of one residents (R1) with record reviewed. R1 overdosed in the facility after taking Fentanyl (narcotic). R1 was revived with Narcan (medication used for overdose) and sent to the hospital. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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).	0 620		

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0 620	Continued From page 3 The findings include: R1's medical record was reviewed. R1 admitted to the licensee on July 26, 2021, and resided there until her death on November 20, 2021. R1's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse. R1's registered nurse (RN) assessment dated October 20, 2021, and completed by RN-A, indicated R1 was oriented to person, place, and time. R1 required assistance with medication management. R1 had a history of drug use, including marijuana and tetrahydrocannibol (THC). R1 was verbally aggressive when not getting her way or when redirected by staff. Staff were to redirect, teach deep breathing, and listen. R1 isolated when feeling depressed. Staff were to encourage R1 to participate in facility activities or go for a walk with staff. R1 was not at risk for elopement. R1 received [24 hours] alone time in the community and three hours alone time in the facility. R1's incident report dated November 15, 2021, and completed by unlicensed personnel (ULP)-B, indicated at 2:20 a.m., R1 was in the upstairs bathroom. ULP-B knocked on the bathroom telling R1 she had to use the bathroom too. R1 responded and told ULP-B to use the downstairs bathroom. ULP-B returned upstairs and found R1 was still in the bathroom with the door locked. ULP-B knocked on the door, calling out R1's name but R1 never responded. At 2:42 a.m., ULP-B called RN-A. RN-A instructed ULP-B to call 911. At 2:45 a.m., emergency medical services (EMS) and law enforcement arrived and forced the bathroom door open and found R1 laying on the floor not talking, but still breathing.	0 620		

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0 620	Continued From page 4 The incident report indicated R1 was revived with oxygen. At 3:42 a.m., R1 was transported to a hospital. R1's hospital record dated November 15, 2021, indicated EMS arrived at the facility and found R1 unrousable, lying on the bathroom floor with gasping respirations. Drug paraphernalia laid on the floor next to R1. In addition, law enforcement found an oxycodone pill in the palm of R1's hand. At the facility, EMS revived R1 with Narcan. Hospital doctors suspected R1 used opioids on a regular basis due to R1's altered mental status. R1 admitted to smoking Fentanyl earlier in the night and taking an unknown pill she obtained from a friend. R1 reported she was "stressed." Hospital staff educated R1 on her opiate overdose and avoiding street drugs. On November 15, 2021, at 7:54 a.m., R1 was discharged back to the facility. R1's record lacked evidence A MAARC report was filed for her drug overdose on November 15, 2021. overdose. On April 28, 2022, at 1:52 p.m., RN-A stated she completed MAARC reports. The licensee policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated January 1, 2022, indicated all staff were mandated reporters and were annually trained on identifying and reporting suspected maltreatment of vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		

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0 630	Continued From page 5	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) that listed specific interventions addressing a recent drug overdose for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1's medical record was reviewed. R1 admitted to the licensee on July 26, 2021, and resided there until her unintentional overdose and death on	0 630		

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0 630	Continued From page 6 November 20, 2021. R1's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse. R1's registered nurse (RN) assessment dated October 20, 2021, and written by RN-A, indicated R1 was oriented to person, place, and time. R1 required assistance with medication management. R1 had a history of drug use, including marijuana and tetrahydrocannibol (THC). R1 was not at risk for elopement. R1 had [24 hours] alone time in the community and three hours alone time in the facility. R1's incident report dated November 15, 2021, and written by unlicensed personnel (ULP)-B, indicated at 2:20 a.m., R1 was in the upstairs bathroom. ULB-B knocked on the bathroom telling R1 she had to use the bathroom too. R1 responded and told ULP-B to use the downstairs bathroom. ULP-B returned upstairs and found R1 was still in the bathroom with the door locked. ULP-B knocked on the door, calling out R1's name but R1 never responded. At 2:42 a.m., ULP-B called RN-A. RN-A instructed ULP-B to call 911. At 2:45 a.m., emergency medical services (EMS) and law enforcement arrived and forced the bathroom door open and found R1 laying on the floor not talking, but still breathing. The incident report indicated R1 was revived with oxygen. At 3:42 a.m., R1 was transported to a hospital. R1's hospital record dated November 15, 2021, indicated EMS arrived at the facility and found R1 unarousable, with gasping respirations, lying on the bathroom floor. Drug paraphernalia laid on the floor next to R1, along with an oxycodone pill in the palm of her hand.R1's R1's hospital record indicated doctors suspected R1 used opioids on a	0 630		

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0 630	Continued From page 7	0 630		

regular basis due to R1's altered mental status. R1 admitted to smoking Fentanyl earlier in the night and taking an unknown pill she obtained from a friend. R1 reported she was "stressed. Hospital staff educated R1 on her opiate overdose and avoiding street drugs. On November 15, 2021, at 7:54 a.m., R1 was discharged back to the facility.

R1's care plan, updated November 16, 2021, indicated R1 would receive safety checks every two hours.

R1's Individual Abuse Prevention Plan (IAPP), updated November 16, 2021, and written by RN-A, R1, indicated R1 was vulnerable to self-injurious behaviors due to R1's history of THC and marijuana use. Staff would educate R1 on the consequences and the importance of not using drugs in the facility.

R1's IAPP failed to address R1's drug overdose with listed specific interventions that addressed R1's vulnerability with opioids.

On April 28, 2022, at 1:52 p.m., RN-A stated she was in charge of developing IAPP and service plans. RN-A stated IAPPs were revised whenever a resident experienced a change-in-condition.

The licensee policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated January 1, 2022, indicated all staff were mandated reporters and were annually trained on identifying and reporting suspected maltreatment of vulnerable adults.

TIME PERIOD TO CORRECT: Seven (7) days.

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EMPATHY HOME CARE INC	**3309 80TH AVENUE NORTH BROOKLYN CENTER, MN 55443**

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01610	Continued From page 8	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial nursing assessment of the physical and cognitive needs of a prospective resident prior to or at the time the resident was admitted to licensee for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01610		

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01610	Continued From page 9	01610		

Findings include:

On April 28, 2022, at 10:55 a.m., the investigator arrived at the licensee's office and was met by registered nurse (RN)-A. RN-A stated she was the RN, owner, and a licensed assisted living director (LALD) for the facilities. RN-A stated the facility currently had no residents residing in the facility but stated it still had an active assistive living license. During the entrance conference, the investigator provided RN-A with a requested list of R1's documents, which included an initial assessment.

R1's medical record was reviewed. R1 admitted to the licensee on July 26, 2021, and resided there until her death on November 20, 2021. R1's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse.

RN-A provided the following assessments performed on R1. The assessments indicated the types and dates the assessments were performed:

*August 9, 2021: 14-Day Assessment; (provided onsite, April 28, 2022)
*September 27, 2021: 90-Day Assessment; (provided onsite, April 28, 2022)
*October 20, 2021: Admission Assessment; (emailed May 2, 2022)
*November 15, 2021: Change-in-Condition assessment; (provided onsite, April 28, 2022)

R1's record lacked evidence the RN conducted an initial assessment prior to or at the time R1 was admitted.

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01610	Continued From page 10 On April 28, 2022, at 1:52 p.m., RN-A stated her main role was performing nursing assessments. RN-A stated she performed pre-admission, admission, 14-day, 90-day, annual, and change-in-condition assessments. The undated licensee policy titled Assessments, indicated the RN would conduct a nursing assessment on the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves into, whichever was earlier. TIME PERIOD TO CORRECT: Seven (7) days.	01610		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 11 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident's service plan included all the services that were provided for one of one resident (R1) with records reviewed. In addition, the licensee failed to ensure R1 received all her scheduled services as indicated in R1's record, including scheduled safety checks. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: On April 28, 2022, at 10:55 a.m., the investigator arrived at the licensee's office and was met by registered nurse (RN)-A. RN-A stated she was the RN, owner, and a licensed assisted living director (LALD) for the facilities. RN-A stated the facility currently had no residents residing in the facility but stated it still had an active assistive living license. During the entrance conference, the investigator provided RN-A with a requested list of R1's documents, R1's medical record was reviewed. R1 admitted to the licensee on July 26, 2021, and resided	01640		

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01640	Continued From page 12 there until her overdose and death on November 20, 2021. R1's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse. R1's incident report dated November 15, 2021, and completed by unlicensed personnel (ULP)-B, indicated at 2:20 a.m., R1 woke up and used the bathroom. A few minutes later ULP-B knocked on the bathroom telling R1 she had to use the bathroom too. R1 told ULP-B to use another bathroom. Fifteen minutes later ULP-B returned and knocked on the bathroom door calling out R1's name but R1 never responded. At 2:42 a.m., ULP-B called registered nurse (RN)-A who told ULP-B to call 911. At 2:45 a.m., Emergency medical services (EMS) and law enforcement arrived. Law enforcement forced the bathroom door open and found R1 laying on the floor not talking, but still breathing. The incident report indicated R1 was given oxygen. At 3:42 a.m., R1 was transported to a hospital. R1's hospital record dated November 15, 2021, indicated EMS arrived at the facility and found R1 lying on the bathroom floor, unarousable with gasping breathing. Drug paraphernalia laid on the floor next to R1. Law enforcement found a pill in the palm of R1's hand which was later identified as an oxycodone (narcotic) pill. EMS revived R1 with Narcan (medication used for overdose). Hospital doctors suspected R1 used opioids on a regular basis due to R1's altered mental status. R1 told hospital staff she smoked Fentanyl (narcotic) earlier in the night and took a pill she obtained from a friend. R1 reported she was "stressed. Hospital staff educated R1 on her opiate overdose and avoiding street drugs. On November 15, 2021, at 7:54 a.m., R1 was discharged back to the facility.	01640		

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R1's RN assessment dated November 15, 2021, written by RN-A, indicated RN-A checked off the area for "no changes" in R1's safety, but wrote the following, "needs care conference to evaluate alone time and drug use and prevention plan." R1's mental health case manager (CM)-F and her community access for disability inclusion (CADI) case manager were to be notified. In the comments section RN-A wrote, "R1 overdosed last night and was sent to the hospital. She came right back after she was assessed. CM-F informed about the incident and care meeting will be scheduled to review her care plan and needs." R1's assessment was signed and dated by RN-A on November 19, 2021.

R1's record lacked evidence a care meeting was scheduled.

R1's care plan updated November 16, 2021, and completed by RN-A, indicated R1 self-isolated when depressed. R1 was provided twenty-four hours of alone time in the community and three hours of alone time in the facility. The R1 was to receive safety checks every two hours while in the facility due to her first overdose. Staff were to closely monitor and perform frequent safety checks and report any signs of drug use, change in behavior, or isolation in her room.

R1's service plan dated November 19, 2021, indicated R1 received daily assistance with medication administration and a monthly antipsychotic intramuscular injection. In the column, "Description of Services," a box with the statement "I'm okay check service" was checked off. An adjacent column titled, "Frequency," a handwritten note written by RN-A, indicated R1 refused frequent safety checks. Another

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01640	Continued From page 14 "Description of Services" column listed the statement, "It is okay for staff to check on me every (unknown time). If my door is locked it is okay for staff to open the door even if force is warranted." The corresponding frequency column had the "yes" box and "every six hours" checked. In the column titled, "Monitoring and Reassessment Schedule," RN-A indicated R1 agreed to be checked on every six hours. R1's service plan lacked a service for safety checks every two hours and failed to identify which staff were responsible for providing the service per R1's care plan needs. R1's service delivery record dated August 2021 through November 20, 2021, indicated R1 received daily assistance with the following services: bathing, oral hygiene, medication administration, meal preparation three times per day, snacks (two or three per day), socialization, community activities, behavior management, and daily light housekeeping. In addition, R1's service delivery record indicated R1 received weekly assistance with linen change, heavy housekeeping, and shopping two to three times per week with a staff member. R1's service delivery record lacked documentation R1 received her safety checks as indicated in R1's service plan. R1's progress note dated November 15, 2021 (7:00 a.m.-7:00 p.m.), indicated R1 slept in her room. Staff checked in and asked how she was faring; she replied she was doing great and went back to sleep. Staff checked on her every two hours. R1's progress note dated November 16, 2021	01640		

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01640	Continued From page 15 (7:00 a.m.-7:00 p.m.), indicated R1 came out of her room at 8:25 a.m. R1 asked staff to make her something to eat after being administered her medications. Staff asked R1 how she was faring and she replied she was doing good. Staff keep checking on R1 every two hours to ensure she was doing great. She came out of her room at 5:00 a.m., about 5:00 a.m., staff said she check on her. R1 was in her room sleeping. No new concerns. R1's progress noted dated November 17, 2021, at 1:45 p.m., indicated R1 left the facility with a man driving a black Honda. R1 never told staff where she went or when she would return. R1 returned at 6:40 p.m., and headed straight to her room. The staff person documented, "no further concerns to report. Another note dated November 17, 2021, (7:00 a.m.-7:00 p.m.), indicated R1 was in the room when staff checked-in. Night medications were administered. R1 socialized with peers and slept all night. No concerns. R1's progress note dated November 18, 2021, at 8:13 a.m., indicated R1 came out of her room when morning staff arrived. R1 took her medication and ate. R1 told staff she was feeling good. Family member (FM)-D dropped of food and gifts for R1. R1's progress note dated November 19, 2021, at 12:08 p.m., indicated staff went into R1's room to adminsiter her medications. At 1:00 p.m., staff transported R1 to her doctor appointment, returning to the facility at 2:06 p.m.. At 3:00 p.m., R1 ate then went to the store with staff. R1 had dinner then returned to her room. Another note dated November 19, 2021, (7:00 a.m.-7:00 p.m.), indicated R1 was in her room at beginning of shift. She socialized with staff and peers. At 8:40	01640		

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p.m., R1 stepped out of the facility to speak to an unknown person sitting in a van parked close to the facility. Moments later R1 returned to the facility and went to her room after being administered her nighttime medication. ULP-C wrote, R1 slept all night and woke at 3:45 a.m., and was presently in her room sleeping. No concerns.

R1's progress notes lacked documentation R1 refused safety checks.

R1's incident report dated November 20, 2021, at 2:35 p.m., and written by ULP-E, indicated ULP-E knocked on R1's door at 7:00 a.m. and 8:00 a.m., but R1 never responded. Six hours later, at 2:00 p.m., ULP-E went to R1's room to administer her morning medications. ULP-E knocked, but did not get a response from R1. ULP-E forced R1's door open and discovered R1 lying face up, unresponsive. ULP-E checked R1's pulse and called R1's name but R1 did not answer. At 2:50 p.m., ULP-E called 911 and RN-A. Law enforcement arrived and pronounced R1 dead.

On April 28, 2022, at 1:52 p.m., RN-A stated R1 did "everything for herself," and stated R1 was "medically stable," and stated her needs never increased after her first overdose on November 15, 2020, stating R1 required only reminders for cleaning and medication management. RN-A stated safety precautions were implemented after R1's first overdose, stating, "I told staff to make sure you check on R1 and residents every time, every hour; know where they are and know what they are doing to make sure they are okay." RN-A stated safety checks were documented in ULP progress notes. RN-A stated she did not update R1's service plan or IAPP between R1's two drug overdoses, stating "we were all trying to work

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within that week to figure out what happened." RN-A stated R1's behavioral flow chart was used in case R1 had a behaviors. Staff documented R1's behaviors on her flow chart. RN-A stated she defined R1's behaviors as, being aggressive and refusing her medications. RN-A stated staff followed a resident's service plan.

On May 9, 2022, at 3:20 p.m., unlicensed personnel (ULP)-B stated she was unsure if there was there was a dcoument indicating how often staff were to perform safety checks. ULP-B stated she gave a verbal report to incoming staff on services she performed for R1 and other residents. ULP-B stated RN-A talked to staff after R1's first overdose, stating RN-A told staff to try and check in on R1 every hour. ULP-B stated, RN-A told us we know she is an adult, but when she is sleeping you check in on her.

On May 18, 2022, at 12:00 p.m., ULP-C stated R1 did not mind having frequent safety checks. ULP-C stated, "I would knock on her door and I would say, R1 how are you doing, and she would say yes I'm fine." ULP-C stated occasionally R1 would be up all night and would request staff not to knock on her door. ULP-C stated RN-A asked staff to perform more safety checks and monitoring on R1 after her first overdose.

On May 18, 2022, at 2:00 p.m., FM-D stated on November 20, 2021, a ULP told her R1 woke up at 3:45 a.m. to make herself a sandwich then went back into her room. FM-D stated staff knocked on R1's door at 7:00 a.m. and 9:00 a.m., but R1 never responded. FM-D stated several hours later law enforcement knocked R1's door down and found R1 dead with drug paraphernalia "all over the place." FM-D stated she retrieved R1's belongings from the facility two months after

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R1 died, stating, "it was hard." FM-D stated she found five or six unused Narcan doses inside R1's room. FM-D stated facility staff were never trained on Narcan administration.

On May 20, 2022, at 10:00 a.m., ULP-E stated R1 did not mind safety checks. ULP-E stated RN-A told staff to monitor R1 frequently, or every hour between November 15, 2021, and November 20, 2021. ULP-E stated no documentation existed for performing safety checks. ULP-E stated safety checks were documented in R1's progress notes. ULP-E stated on November 20, 2021, at 7:00 a.m., overnight staff told her R1 had been up most of the night and wanted to sleep during the day. The overnight staff told ULP-E not to knock on R1's door so R1 could sleep. ULP-E stated, "because of her first overdose, I always knock on her door, knocking and checking on R1." ULP-E stated she still knocked on R1's door even though the overnight staff told her R1 had been up most of the night. ULP-E stated she briefly checked on R1 every hour during her shift but R1 never responded to ULP-E's knocks. ULP-E stated at 2:00 p.m., another ULP arrived with food. ULP-E went to R1's door to have her come out of her room to eat and take her medications. ULP-E stated when R1 still did not respond, she pushed R1's door open and saw R1 lying on her bed with "stuff" in her hand. ULP-E stated R1 was not breathing and was cold to the touch.

On May 20, 2022, at 10:30 a.m., case manager (CM)-F stated R1 required extra support and could not live independently due to her mental health and history of substance abuse. CM-F stated, "if she was independent, she would not be in customized living." CM-F she did not recall if the facility informed her of R1's first overdose but

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01640	Continued From page 19 stated she would have remembered if they had. CM-F was concerned the facility did not perform safety checks the last hours of R1's life stating, "why did people not check on R1 if she was up at 4:00 a.m. and acting strange, and no one checked on her until 2:00 or 3:00 p.m.?" CM-F stated the facility never informed her R1 was struggling and was told R1's safety checks were decreased to once every six hours between November 15-20, 2021. CM-F stated after R1 passed the facility told her, "well, R1 was starting to get into her old behaviors, going out and leaving." CM-F stated, "I thought why didn't you guys tell us this?" The licensee policy titled Service Plan, dated January 1, 2022, indicated service plans were based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. The service plan was a written plan between a resident or resident's designated representative and the facility about the services that would be provided to the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 20 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: R1's medical record was reviewed. R1 admitted to the licensee on July 26, 2021, and resided	01650		

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	35600	A. BUILDING: ______ B. WING ______	C 04/28/2022

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01650	Continued From page 21	01650		

there until her overdose and death on November 20, 2021. R1's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse.

R1's care plan dated November 16, 2021, indicated R1 was to receive safety checks every two hours while in the facility.

R1's service plan, updated November 19, 2021, indicated R1 received daily assistance with medication administration, housekeeping, meal preparation, and bathing reminders with an unknown frequency. R1 received weekly reminders for laundry and linen change, and a monthly antipsychotic intramuscular (IM) injection. R1's service plan indicated R1's safety checks were decreased to once every sic hours per R1's request.

R1's service plan updated November 19, 2021, indicated R1's service plan lacked the following required information: Fees for services, frequency for bathing and weekly laundry reminders, and the categories of staff providing those reminders.

On April 28, 2022, at 1:52 p.m., registered nurse (RN)-A stated she created resident's service plans based off resident assessments. RN-A stated unlicensed personnel (ULP) followed resident's service plan to determine what cares to provide the residents.

The licensee policy titled Service Plan, dated January 1, 2022, indicated service plans were written agreements between a resident or resident's representative documenting agreement on services to be provided. The licensee would implement and provide all services indicated in the service plan.

Minnesota Department of Health

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01650	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was neglected. Findings include: On June 21, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No plan of correction is required for tag 2360. Please refer to the public maltreatment report (sent separately) for details.	
03000 SS=D	626.557 Subd. 3 DO NOT USE / Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not	03000		

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03000	Continued From page 23 required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	03000		

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03000	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults for one of one residents (R1) with record reviewed. R1 overdosed in the facility after taking Fentanyl (narcotic). R1 was revived with Narcan (medication used for overdose) and sent to the hospital. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1's medical record was reviewed. R1 admitted to the licensee on July 26, 2021, and resided there until her death on November 20, 2021. R1's diagnoses included schizoaffective disorder, anxiety, panic disorder, and history of substance abuse. R1's registered nurse (RN) assessment dated October 20, 2021, and completed by RN-A, indicated R1 was oriented to person, place, and time. R1 required assistance with medication management. R1 had a history of drug use, including marijuana and tetrahydrocannibol (THC). R1 was verbally aggressive when not getting her way or when redirected by staff. Staff were to redirect, teach deep breathing, and listen.	03000		

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03000	Continued From page 25	03000		

R1 isolated when feeling depressed. Staff were to encourage R1 to participate in facility activities or go for a walk with staff. R1 was not at risk for elopement. R1 received [24 hours] alone time in the community and three hours alone time in the facility.

R1's incident report dated November 15, 2021, and completed by unlicensed personnel (ULP)-B, indicated at 2:20 a.m., R1 was in the upstairs bathroom. ULP-B knocked on the bathroom telling R1 she had to use the bathroom too. R1 responded and told ULP-B to use the downstairs bathroom. ULP-B returned upstairs and found R1 was still in the bathroom with the door locked. ULP-B knocked on the door, calling out R1's name but R1 never responded. At 2:42 a.m., ULP-B called RN-A. RN-A instructed ULP-B to call 911. At 2:45 a.m., emergency medical services (EMS) and law enforcement arrived and forced the bathroom door open and found R1 laying on the floor not talking, but still breathing. The incident report indicated R1 was revived with oxygen. At 3:42 a.m., R1 was transported to a hospital.

R1's hospital record dated November 15, 2021, indicated EMS arrived at the facility and found R1 unrousable, lying on the bathroom floor with gasping respirations. Drug paraphernalia laid on the floor next to R1. In addition, law enforcement found an oxycodone pill in the palm of R1's hand. At the facility, EMS revived R1 with Narcan. Hospital doctors suspected R1 used opioids on a regular basis due to R1's altered mental status. R1 admitted to smoking Fentanyl earlier in the night and taking an unknown pill she obtained from a friend. R1 reported she was "stressed." Hospital staff educated R1 on her opiate overdose and avoiding street drugs. On

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03000	Continued From page 26 November 15, 2021, at 7:54 a.m., R1 was discharged back to the facility. R1's record lacked evidence A MAARC report was filed for her drug overdose on November 15, 2021. overdose. On April 28, 2022, at 1:52 p.m., RN-A stated she completed MAARC reports. The licensee policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated January 1, 2022, indicated all staff were mandated reporters and were annually trained on identifying and reporting suspected maltreatment of vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) days.	03000		