Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359913362M
Compliance #: HL359913496C

Date Concluded: September 11, 2024

Name, Address, and County of Licensee Investigated:
Revive Care Services Inc
5111 Irving Ave South
Minneapolis, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
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 the resident when the facility failed to provide services according to the residents' service plan. The resident's family was unable to locate the resident nor reach anyone at the facility by phone or in-person.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's service plan was being followed. The resident was free to come and go as he wishes, there was an alternative phone number to call, and there was staff at the facility.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator interviewed the resident and contacted the resident's family members. The investigation included review of the resident record and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included mental health diagnoses. The resident's service plan included assistance with medication management and behavior management. The resident's assessment indicated the resident is oriented and independent with walking and daily cares.

A concern arose that the resident was unable to be located, the licensed administrator was not answering his phone, and no one answered the door at the facility. Additionally, there was concern for where the resident was and his safety.

During an interview, the resident stated he does leave and stay overnight at a friend's house occasionally. The resident stated he does not sign out when he leaves the facility but does let staff know. The resident stated staff are always at the facility to assist him when he needs help.

During an interview, a family member stated it was impossible to get a hold of the owner for more than four to five months, no one would answer the facility phone, no one would answer the door, and no one took the resident to his appointments. The family member stated the resident missed appointments, which resulted in legal issues for the resident.

During an interview, a manager stated the resident was free to come and go as he wishes and chooses not to sign out. The manager stated the resident lets staff know where he is going and usually lets staff know when he will return. The manager stated on occasion, the resident will not return when he says and when he does not come back within 24-hours, staff will call family or friends to check in on him.

The manager also stated that he was out of the country for about three months, but family was able to call the facility phone. The manager stated there was always staff at the facility and if someone did not answer the door, they could have been downstairs cleaning or in the bathroom.

The investigation included an unannounced visit and facility staff members were found to be present at the facility.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	35991	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVIVE CARE SERVICES INC	5111 IRVING AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On August 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL359913496C/#HL359913362M. No correction orders are issued.	0 000		