Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL36561001M
Compliance #: HL36561002C

Date Concluded: December 6, 2021

Name, Address, and County of Licensee Investigated:
Healing Homes Living Services
83 Cook Avenue West
St. Paul, MN 55117
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Substantiated, facility 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 facility staff failed to provide the resident with appropriate supervision and services to ensure the resident's safety.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The resident's assessed care planned needs included medication management by facility staff and 24-hour staff supervision due to the resident's history of overdosing medications and poor decision making. Although the facility was aware of the residents safety needs, facility staff arranged for the resident to stay overnight at hotels, and allowed the resident to stay with a boyfriend or a family member without arrangements for staff supervision and/or medication assistance. The resident took an unknown illegal drug, drank alcohol, and prostituted when out of the facility.

The investigation included interviews with facility staff members, including administrative staff. In addition, the investigation included a review of the resident's medical record, facility policies and procedures, and documentation obtained by a prior onsite survey of the facility.

The resident had diagnoses including bipolar disorder, post-traumatic stress disorder, anxiety, depression, and suicidal ideation. The resident made her own decisions and required assistance from facility staff for medication management, hair washing, reminders to groom, meal preparation, and 24-hour staff supervision.

The resident's community support plan developed by the state about four months prior to the resident's admission to the facility indicated the resident's history included prostitution, human trafficking of others at a young age, and drug and alcohol abuse. The plan indicated the resident required assistance with medication management, did not trust herself when struggling emotionally, and may misuse medications. The resident required assistance with meal preparation.

The resident's state service agreement indicated the state paid the facility for providing 24-hour customized daily living.

The resident's facility service agreement indicated the resident required the facility to provide three meals a day with snacks, transportation, licensed nurse services, medication administration and reminders, insulin injections, blood glucose monitoring, and nebulizer treatments seven days a week.

The resident's facility vulnerability assessment indicated the resident required staff to administer and fully assist the resident with all medications, and the resident had a history of self-abuse including alcohol use and overuse of medications. The assessment failed to identify the resident's previous history of abuse of others.

The resident's progress notes indicated over a period of approximately eight weeks on seven occasions, facility staff either planned for or were aware of the resident staying a weekend in a hotel or overnight with either a boyfriend or family member without arrangements for staff supervision or assistance with medication administration. During one early morning the resident contacted facility staff from a hotel she was staying at and told them she needed an immediate ride to the facility. The resident told staff, "I need to get out of here [hotel] right away." The resident said she prostituted to make money and was drinking alcohol. The following day, the resident told staff she planned to stay overnight, out of state, with a family member. The next day, the resident told staff when she was with family she drank so much alcohol she blacked out, did not remember how she got back to the facility, and lost her purse and cell phone. One day later at the resident's outpatient treatment, the resident tested positive for Fentanyl (opioid narcotic medication). Despite staff awareness of the resident's need for 24-hour supervision and poor decision-making skills, the staff arranged for another unsupervised weekend at a hotel.

During the resident's overnight leaves from the facility, staff arranged for the resident to take her medication with her to self-administer. In addition, almost every weekday during the nearly

five months the resident resided at the facility, staff sent the resident to outpatient treatment with her medications to self-administer.

During interview, the resident's county case manager (CCM) stated the facility was receiving payment for providing the resident services which included 24-hour staff supervision, meals, and assistance with medication administration. The CCM indicated according to the resident, facility staff provided the ride to the hotel without any arrangements for meals. The resident used prostitution as a way to make money in order to eat. The CCM indicated due to the resident's high-risk behaviors she required the supervision and assistance from staff and should not take extended leaves from the licensee residence.

During interview, the owner stated she arranged for the resident to stay at the hotel as an "outing" for the resident. Staff did not supervise the resident when out of the facility. The owner used the company credit card to pay for the hotel room. The owner denied awareness of the resident's prostitution.

In conclusion, neglect of supervision 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:
(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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No attempted but unable to contact.
Family/Responsible Party interviewed: No the resident was her own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The resident's county case manager arranged for the resident to move to another location for services.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
St. Paul City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	**83 COOK AVENUE WEST SAINT PAUL, MN 55117**

(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 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: #HL36561002C/#HL36561001M On November 22, 2021, 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 zero clients receiving services under the provider's Assisted Living license. The following correction order is issued for #HL36561002C/#HL36561001M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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 interviews, and document review, the facility failed to ensure one of one resident, R1, was free from maltreatment. R1 was neglected. Findings include: On December 6, 2021, 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. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	