Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366381962M
Compliance #: HL366389745C

Date Concluded: June 24, 2024

Name, Address, and County of Licensee Investigated:
Charity Care
10909 Brittany Drive North
Champlin, MN 55316
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 when the resident went on a bike ride at 9:00 p.m. during cold weather. The resident died after a vehicle struck him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was his own decision maker and chose to ride his bike in cold weather, use alcohol, and laid down on a roadway. The facility had prior knowledge of the resident's mental illness symptoms and implemented a safety plan. Staff did not suspect the resident was planning to harm himself, but filed a missing person report with law enforcement one hour after the resident left the facility per the resident's plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, medical examiner investigation, hospital records, facility internal investigation,

facility incident reports, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included post-traumatic stress disorder and personality disorder. The resident was his own decision maker and was independent with activities of daily living. The resident's service plan included reminders for activities of daily living, medication administration, and assistance with behaviors. The resident's assessment indicated although the resident preferred not to have staff enter his room, he was agreeable to staff calling his cell phone to check on him every hour when he was in his room or out of the facility.

An incident report indicated staff observed the resident go outside, get on his bike, and leave the facility without notifying staff where he was going. The report indicated the staff called the resident's phone multiple times with no answer, and after an hour staff called the police to report him missing. The report indicated an officer came to the facility several hours later to notify the facility the resident was involved in an accident.

During an interview, a staff member stated the resident had some paranoia and periods of verbal aggression, however, but on the day of the incident the resident was his normal self. The staff member stated the resident went outside to smoke and he was dressed appropriately for the cold weather. The staff member stated she called law enforcement to file a missing person's report and then notified an administrator.

During an interview, the administrator stated she interacted with the resident on the day of the incident and noted nothing unusual about his behavior. The administrator stated the police told her the resident was laying on a road, run over by a vehicle, and passed away.

The medical examiner investigation indicated the resident had alcohol in his system and there was additional evidence at the scene which led to the determination the manner of death was suicide.

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: Deceased.
Family/Responsible Party interviewed: Emergency Contact was interviewed.
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
	36638	A. BUILDING: _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARITY CARE INC	10909 BRITTANY DRIVE NORTH CHAMPLIN, MN 55316

(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 June 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL366389745C/#HL366381962M. No correction orders are issued.	0 000		