

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL366493203M  
**Compliance #:** HL366493269C

**Date Concluded:** October 10, 2024

**Name, Address, and County of Licensee**

**Investigated:**

Immaculate Home Care  
1390 Beech Street  
St Paul MN, 55106  
Ramsey County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Kris Detsch, 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 the resident when they failed to provide medications and supervision. As a result, law enforcement found the resident minimally responsive with drug paraphernalia around him.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The facility took reasonable actions to prevent the event from occurring. The resident left the facility on his own accord and used substances with other individuals in the community. The event occurred after the facility made multiple attempts to address these concerns with the resident and his medical providers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers. The investigation included review of the resident records, personnel files, and related facility policy and

procedures. Also, the investigator toured the facility and observed the resident's environment and the facility's system for medication management.

The resident resided in an assisted living facility. The resident's diagnoses included depression, anxiety, substance abuse disorder, and tardive dyskinesia (movement disorder). The resident's service plan included assistance with behavior management for verbal and physical aggression. The resident's nursing assessment indicated he required minimal assistance with daily cares. He could communicate his needs but had some difficulty making decisions.

The resident's care plan indicated the resident understood his diagnoses and independently cared for himself when he went outside of the facility. The care plan indicated the facility would notify law enforcement if the resident did not return to the facility seven days after he left. The resident completed this document seven months prior to the incident.

The resident's progress notes indicated he left the facility and did not return. Six days later the nurse went to the hospital, asked if they had seen him and discovered he was there recovering from a fentanyl overdose. Paramedics brought the resident to the hospital after a neighbor called law enforcement. Law enforcement found the resident unresponsive, in an apartment, with another individual who was deceased. The notes indicated the resident said he only remembered smoking "weed", then "passing out".

During an interview, the nurse said the resident left the facility frequently on his own accord and would not return. The facility provided cell phones for him, but he lost them, so they could not reach him. The facility called law enforcement multiple times within twenty-four hours of him being gone, but law enforcement was frustrated over the numerous calls, so she met with the resident and his case worker. They determined the facility could not prevent him from leaving and he could come and go freely as he chose. The nurse said the resident told them not to call law enforcement until he had been gone for seven days and they came up with an agreement regarding this course of action. The nurse said the resident refused interventions from medical providers, canceled multiple medical appointments, and even switched medical providers and health care systems. The nurse said she made medical appointments and coordinated care with his providers, but he refused to attend those appointments. Additionally, the resident refused medications to manage his behaviors. The nurse said the resident returned to the facility after this incident, and she obtained Narcan (medication to reverse the effect of opioid drugs). The nurse said she trained the facility staff how to use the medication, however the resident did not use street drugs while in the facility; this behavior occurred outside the facility.

During an interview, the case worker stated the resident had the right to come and go freely from the facility. The case worker indicated he tried to schedule meetings with him, called him before going to the facility and he would leave the facility without telling anyone. The case workers stated he received updates from the facility. The case worker stated they provided

person centered care. The case worker said the resident did not have a legal guardian, he was free to make his own decisions, even when they were not good decisions.

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. Declined interview.

**Family/Responsible Party interviewed:** Not Applicable.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

The facility coordinated the resident's care with case workers. The facility obtained Narcan and trained staff on how to administer the medication.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36649</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>IMMACULATE HOME CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1390 BEECH STREET SAINT PAUL, MN 55106</b>
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(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	<p><b>Initial Comments</b></p> <p>On September 30, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL366493269C/#HL366493203M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_