Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366799688M
Compliance #: HL366797763C

Date Concluded: March 6, 2024

Name, Address, and County of Licensee Investigated:
Universal Health Services LLC
7300 Russell Avenue South
Richfield, MN 55423
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, 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 provide supervision and safety checks for the resident. The resident overdosed and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility followed the resident's plan of care and did perform safety checks. The facility found the resident unresponsive due to safety checks and activated emergency medical services appropriately.

The investigator conducted interviews with facility staff members, administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record, facility incident reports, facility internal investigation, related facility policy and procedures, law enforcement reports, and the resident's death record.

The resident resided in an assisted living facility. The resident's diagnoses included borderline personality disorder, mild mental disability, generalized anxiety disorder, post-traumatic stress disorder, amphetamine disorder, opioid-use disorder, and cocaine use disorder. The resident's service plan included assistance with medication and behavioral management.

The resident's assessment indicated her speech clarity had worsened due to missing teeth and impairment from chemical abuse, she had balance problems, was at risk for falls and general safety due to impairment related to a history of chemical abuse. The assessment further indicated the resident had vulnerabilities related as history of drug abuse and drug overdoses. While the resident had the right to leave the facility, she did have a history of seeking out drugs.

The facility's internal investigation document indicated the resident began the day shopping with a family member and returned to the facility midmorning. The document indicated the resident was frequently in and out of the facility throughout the rest of the day and returned to the facility around 6:00 p.m. The resident ate some of her dinner and socialized with staff for before going to her room to finish her dinner. At approximately 6:30 p.m., a staff member conducted a routine safety check and attempted to provide the resident medications. The document indicated the staff member found the resident's bedroom door locked from the inside. Following two more safety checks, at approximately 7:10 p.m. and 7: 30 p.m., without a response from the resident, the staff member contacted the nurse in charge for further directions.

The facility's internal investigation document indicated the nurse in charge advised staff to forcefully enter the room. When staff entered the room, the resident was found sitting on the floor, with her food on her lap, unresponsive. Emergency medical services was called. The document indicated when emergency personnel arrived, the resident deceased related to suspected drug overdose.

The law enforcement report indicated a call was received for someone not breathing. When the officer arrived on scene, he was told the victim was pronounced dead on arrival by the fire department personnel when they arrived at approximately 8:14 p.m.

The law enforcement report indicated the unlicensed personnel told the officer he attempted to enter the resident's room at 6:00 p.m. to give the resident scheduled medication but the door was locked. The unlicensed personnel told the officer at approximately 7:58 p.m. he entered the resident's room, found the resident leaning against the bed, not breathing, and called the supervisor.

The law enforcement report indicated officers found drug evidence of drug use in the resident's room.

The resident's death record indicated the cause of death was mixed fentanyl, bromazolam, and xylazine (a non-opioid sedative or tranquilizer that can be life-threatening and especially dangerous when mixed with opioids like fentanyl) intoxication.

A review of the resident's medical record indicated the resident had a history of drug use and overdosing while at the facility multiple times. In those other instances the facility was able identify the concern and get the resident the help, such as Narcan and hospitalization, successfully.

During the month prior to her death, the resident's progress notes indicated the resident had episodes of disorientation, slurred speech, and an unsteady gait. The notes indicated the resident was out of the facility on two separate leaves for a total of ten days during the month, prior to the death incident.

During an interview, an unlicensed staff member stated he arrived at the facility for his shift around 6:00 p.m. and the resident was in her room. The unlicensed staff member stated he went to the residents' room shortly after 6:00 p.m., knocked on the door, but the resident did not respond, and the door was locked. The unlicensed staff member stated he did not enter the residents' room in case she was sleeping. The unlicensed staff member stated he returned to the resident's room around 7:00 p.m. to check on the resident and give medications but she still did not respond so he called the nurse. The unlicensed staff member stated the nurse told him to use a kitchen knife to enter the resident's room because the master key was not working. The unlicensed staff member also stated the nurse remained on facetime with him while he entered the resident's room. The unlicensed staff member stated when he entered the room, the resident was sitting on the floor with her back against the bed and she was unresponsive. The unlicensed staff member stated the nurse called emergency medical services immediately.

During an interview, the nurse stated staff called her to inform her they had been to the resident's room to check on her and give her medication three times, but the resident would not answer, and the door was locked. The nurse stated she told the staff to forcefully enter the room. The nurse stated she remained on a facetime call while staff entered the room and found the resident unresponsive. The nurse stated she called emergency medical service immediately. The nurse stated she instructed the staff to check for a pulse. The nurse further stated staff did not begin cardiopulmonary resuscitation (CPR) because there were notable signs of death.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident and call 911.

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
	36679	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH SERVICES LLC	7300 RUSSELL AVENUE SOUTH RICHFIELD, MN 55423

(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 February 7, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL366797763C/#HL366799688M. No correction orders are issued.	0 000		