Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL367568604M
Compliance #: HL367565875C

Date Concluded: April 23, 2024

Name, Address, and County of Licensee Investigated:
Arms Home Health Care
1904 E 26th St.
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kathy Barnhardt, RN
Michele Larson, RN
Special Investigators

Finding: Substantiated, facility responsibility

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 after they failed to provide supervision and monitoring. The resident overdosed four times while in and on facility property. The resident died from his fourth overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to implement interventions to provide for the resident's health and safety following the resident's three prior drug overdoses before resident #1's death from the fourth overdose.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident' case manager. The investigation included review of resident record, death record, hospital records, facility

internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included polysubstance abuse, schizophrenia, and borderline intellectual functioning. The resident's service plan indicated the resident was independent with activities of daily living (ADL's). Staff were directed to ensure the resident remained safe and stable. The resident's behavioral plan indicated the facility implemented interventions for the resident's agitation, anxiety, and verbal aggression but did not implement interventions for the resident's multiple drug overdoses. The resident's assessment indicated the resident was "very" vulnerable to be influenced by others and had a history of drug and alcohol abuse.

The medical record indicated the resident had three drug overdoses while he resided in the facility prior to the fourth drug overdose that caused his death. Two of the four drug overdoses occurred 24 hours apart with drug paraphernalia found in the resident's possession. All four overdoses occurred on facility property. After each drug overdose, emergency medical services (EMS) administered an opioid reversal drug (Narcan) and transported the resident to the hospital for observation and treatment. The resident returned to the facility after each hospital discharge with a prescription for Narcan. The record lacked documentation a facility registered nurse assessed the resident, implemented interventions, and/or updated his service plan to reflect the resident's increased need for supervision and monitoring after his overdoses. In addition, following the drug overdoses, the resident left the facility for hours at a time without staff knowing his whereabouts.

Hospital discharge records indicated the resident's safety and well-being were at imminent risk due to the use of "intoxicating substances" on a regular basis. Hospital discharge summaries provided to facility nursing staff after each overdose included a list of the illegal drugs known to be used by the resident. Hospital psychiatry notes advised the facility to be aware of the resident's borderline intellectual functioning while providing for the resident's cares.

A police report indicated the resident was last seen alive one night at 11:00 p.m. and not seen until 10 hours later when another resident told facility staff the resident was "dead" in the backyard. The resident was wedged against the facility garage with a blue straw and lighter next to his body. Law enforcement checked the resident's room where they found a glass pipe commonly used to smoke crack cocaine. Facility staff reported the resident became hostile and aggressive towards staff when they questioned his drug use.

During an interview, facility administration stated they were aware of the resident's drug history, however, were unsure what type of drug the resident used. Facility administration stated they observed the resident while he was in the facility, however, the staff were unable to stop or prevent the resident from leaving or using drugs on or off site. Facility administration confirmed the resident required 1:1 supervision and they attempted to negotiate more money

from the county case manager for the services however, the increased supervision was never implemented prior to the resident's death.

During investigative interviews, facility staff members stated they were aware of the resident's drug use and stated "a lot of drugs" were used by the resident. Facility staff members stated the resident left the facility often without staff knowledge of where the resident went or who he was with. Facility staff stated it was not uncommon for the resident to be gone for hours at a time or to leave at night and return in the next morning. Facility staff stated it was typically 24 hours of a residents' absence before staff were concerned. Some staff would notify facility administration if residents were out of the facility for an entire shift but stated that did not always occur.

In conclusion, the Minnesota Department of Health determined neglect 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 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. Deceased.
Family/Responsible Party interviewed: No. Several attempts to reach family. No response from family.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility conducted an internal investigation, contacted law enforcement, and filed a report with Minnesota Adult Abuse Reporting Center (MAARC).

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

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minneapolis Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36756	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMS HOME HEALTH CARE	1904 EAST 26TH STREET MINNEAPOLIS, MN 55404

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER 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: #HL367565875C/#HL367568604M On April 3, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL367565875C/#HL367568604M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State 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.	
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 1 standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement interventions, including adequate supervision and monitoring for two of two residents (R1, R2) that were consistent with their needs and current standards of practice. In addition, the licensee failed to ensure the facility registered nurse (RN)-A reassessed R1 and R2, updated their service plans and individual abuse prevention plans (IAPP) to reflect their increased needs after R1 and R2's drug. R1 had four drug overdoses while he resided at the licensee' facility. The fourth overdose resulted in R1's death. R2 had two drug overdose while residing in the facility. This failure had the potential to lead to serious injury, impairment, or death for R2. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee's facility on April 1, 2022, and resided there until his drug overdose and death on September 20, 2023. R1's diagnoses included polysubstance abuse, borderline intellectual functioning, and schizophrenia.	02310		

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02310	Continued From page 2 R1's service plan dated April 1, 2022, indicated R1 was independent with personal cares but required assistance with medication management and meals. R1 walked independently. Staff were to ensure R1 remained safe and stable. R1's incident report dated February 1, 2023, at 11:09 p.m., indicated R2 found R1 unconscious on facility property. R1 sat against the garage with purple lips. Facility staff called 911 who advised staff to administer an opioid reversal medication (Narcan). Emergency medical services (EMS) arrived minutes after staff unsuccessfully attempted to administer two doses of Narcan. EMS transported R1 to the hospital. On February 2, 2023, at 2:43 a.m., R1 was discharged back to the facility with a prescription for Narcan. R1's record lacked evidence his service and behavioral plans were updated or interventions were implemented that addressed his vulnerability to overdosing on drugs. In addition, R1's record lacked documentation a facility RN reassessed him following the overdose. R1's hospital record dated February 2, 2023, at 11:34 p.m., indicated 24 hours later, R1 was transported back to the hospital for his second drug overdose after staff reported R1 acted "erratic," and had drug paraphernalia in his possession. R1's record lacked evidence R1 was supervised and monitored after his first drug overdose in order to prevent or reduce the risk of a second overdose. R1's record lacked documentation a facility RN reassessed R1 after the second drug overdose. R1's progress note dated August 4, 2023, at 9:40 p.m., indicated at 6:00 p.m., R1 walked to the backyard and relaxed outside until two hours later	02310		

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02310	Continued From page 3 when he suffered his third overdose on facility property. RN-A instructed staff to call 911 and administer Narcan. Emergency medical services transported R1 to the hospital. R1's hospital record dated August 4, 2023, at 9:19 p.m., indicated R1 arrived with an altered mental status (AMS) due to an opioid overdose. A second dose of Narcan was administered at the hospital due to R1's respiratory and altered mental status. The hospital record indicated hospital staff suspected R1 used "intoxicating substances" on a regular basis and his altered mental status "imminently endangered" his safety and well-being. On August 4, 2023, at 10:18 p.m., R1 was discharged to the facility. R1's record lacked documentation the facility implemented interventions after his third overdose to ensure R1's safety and lacked evidence facility staff supervised and monitored him after his return to the facility. R1's record lacked evidence a facility RN reassessed him or updated his service and behavioral plans after his discharge from the hospital. R1's police report dated September 20, 2023, at 9:53 a.m., indicated at 9:09 a.m., police were dispatched to the facility after staff reported R1 was "down and unresponsive" on facility property. R1 was last seen alive on September 19, 2023, at 11:00 p.m. during overnight checks, and not seen again until 10 hours later (9:00 a.m.) when he was found deceased. A blue straw and lighter laid next to R1's body. Police checked R1's room and found a glass pipe commonly used to smoke crack cocaine. ULP-D told police R1 became aggressive when staff questioned his drug use. On April 11, 2024, at 11:00 a.m., RN-A confirmed R1 had four overdoses while he resided at the	02310		

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02310	Continued From page 4 facility, but stated the facility did all that they could for R1, stating the facility could only observe R1 but was unable to stop or prevent him from using drugs. RN-A stated she was unsure what drugs R1 used stating, "I would never know what they used." RN-A stated R1 required 1:1 supervision and RN-A attempted to negotiate payment for 1:1 supervision with his case manager after R1's 2nd overdose, but stated it was difficult because it required more money from the county. Although RN-A stated she updated services and behavioral plans and performed assessments after any change of condition, she was unable to explain why R1's service and behavioral plans were never updated or why R1 was never reassessed after his drug overdoses. R2 admitted to the licensee's facility on April 7, 2022, and was homeless prior to his admission to the facility. R2's diagnoses included drug and alcohol abuse with intoxication and schizoaffective disorder. R2's progress note dated October 25, 2022, at 7:27 p.m., indicated R2 looked unwell, vomited, and appeared intoxicated. RN-A indicated due to R2's history of opioid abuse, possible overdose was suspected. RN-A advised staff to call 911 if R2's condition declined. R2's progress note dated October 26, 2022, at 12:39 a.m., indicated on October 25, 2022, at 11:30 p.m., R2 had severe sleepiness, abnormal breathing, and did not respond to staff. Emergency medical services (EMS) arrived and transported R2 to the hospital. R2's hospital record dated October 26, 2022, at 12:51 a.m., indicated R2 overdosed in his room at the facility. Facility staff found R2 unresponsive	02310		

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02310	Continued From page 5 and not breathing (apneic). EMS manually resuscitated R2 with manual ventilation bag and administered Narcan due to R2's inability to breathe on his own. A medical provider indicated "I am highly concerned that they (R2) have a problem with chemical dependency and they (R2) cannot make safe decisions for themselves. This endangers their (R2)'s well-being and safety." R2's record lacked evidence the facility implemented interventions after he was discharged from the hospital, and lacked documentation a facility RN assessed R2 after he returned to the facility following the drug overdose. R2's progress note dated October 26, 2023, at 10:38 p.m., indicated R2 arrived at the facility "clearly inebriated" after having been out for an undetermined time. R2's progress note dated October 29, 2023, at 7:33 a.m., indicated R2 came out of his room acting distraught and confused. Facility staff indicated R2 appeared, "not in his right state of mind," and indicated the previous night was "much more severe and different." R2's progress note did not indicate staff notified RN-A or called 911. R2's record lacked evidence facility staff supervised and monitored R2 to ensure his safety, or a facility RN assessed R2 after he displayed a change in condition. R2's incident report dated January 6, 2024, at 10:05 p.m., indicated R2 arrived at the facility extremely intoxicated with an unsteady gait. Facility staff escorted R2 to his room. Moments later staff heard a loud noise from R2's room where they found R2 lying on the floor. R2's closet door was broken with nails and pieces of	02310		

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02310	Continued From page 6 wood scattered around R2. R2 appeared uninjured. Facility staff did not call 911 but were instead advised by RN-A to monitor R2 throughout the shift. R2's record lacked evidence facility staff supervised and monitored him to ensure his safety, or a facility RN assessed R2 after he displayed a change in condition. R2's assessment dated February 15, 2024, indicated R2 had a "very limited" support network. R2's care plan dated February 15, 2024, indicated staff could enter R2's room without permission if there was concern for his safety. R2's IAPP dated February 15, 2024, indicated R2 was vulnerable to being abused by others due to his intoxication issues with drugs and alcohol. R2's IAPP lacked interventions for his assessed vulnerabilities to drugs and alcohol. R2's behavioral plan dated April 8, 2024, included interventions to manage R2's behaviors for agitation, anxiety, mental health, property destruction, and verbal, physical aggression. R2 had intoxication issues with drugs and alcohol. R2's behavioral plan failed to specifically address R2's drug overdoses or implement interventions. R2's service plan dated April 8, 2024, indicated R2 received two daily safety checks in the morning and the overnight shift. Staff were to ensure R2's safety and well-being. R2 was under the influence at all times. R2's service plan failed to address his recent overdose or increased need for supervision and monitoring. Review of R2's progress notes between October 2022 and April 12, 2024, indicated multiple times when R2 left the facility for hours at a time during	02310		

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02310	Continued From page 7 day and night shifts with staff not knowing his whereabouts or notifying RN-A. On April 11, 2024, at 5:00 p.m., ULP-B stated R1 and R2 used "a lot of drugs," and would go outside together and brought drugs to their rooms. On April 15, 2024, at 2:28 p.m., R2's case manger (CM)-E stated R2 had two, possibly three overdoses while he resided at the facility. CM-E stated R2 had a "triple whammy" because of his drug abuse, schizophrenia, and low cognition. The licensee's policy titled, Scope of Service, dated August 1, 2021, indicated when a referral is received for a resident with complex medical or behavioral needs, the RN would determine the licensee's ability to provide the level of service required. If the resident was admitted, the RN was responsible for establishing protocols for the cares required, orienting all staff to the resident's individual care plan, and evaluating the appropriateness of the protocol for the resident and updating it as indicated. TIME PERIOD TO CORRECT: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment 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: The facility failed to ensure one of two residents reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 8 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		