Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL367949026M
Compliance #: HL367946553C

Date Concluded: June 14, 2024

Name, Address, and County of Licensee Investigated:
Multicultural Care Center LLC
3647 North 6th Street
Minneapolis, MN 55412-2126
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when the resident died as a result of a fentanyl overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided appropriate care per the service plan. The resident was independent in making social and financial decision-making while the facility reviewed with the potential risks of the choices the resident made.

The investigator conducted an interview with a nursing staff member. The investigation included review of the resident record, law enforcement reports, and facility policies.

The resident resided in an assisted living facility. The resident's diagnoses included multiple mental health diagnoses. The resident's service plan included assistance with bathing, dressing,

meals, and medication administration. The resident was independent with mobility and finances and relied on others or the bus for transportation. The resident's vulnerability assessment indicated he had a history of alcohol and illegal substance abuse. Staff were to report suspicious behavior or use of these substances to the nurse. Staff performed random room checks as the resident was known to hoard items.

Review of the resident's progress notes indicated staff documented safety checks on the resident. The notes indicated that one time the resident left the facility and did not return that night which prompted staff to file a police and vulnerable adult report.

The resident's progress notes indicated one morning the resident woke around 4 a.m., asked for his medications, ate an orange, and went back to bed around 7 a.m. The notes did not indicate any concerns at that time. The staff member performed a safety check on the resident around 10:30 a.m. and noted the resident was not moving or respond to his name, so she called 911. Police arrived and found the resident deceased. Progress notes indicated that police on scene noted a drug-type smell and suspected the resident may have died of a drug overdose, which was confirmed by autopsy. The progress notes indicated he had been out of the home multiple times that week, but staff did not note concerns of drug possession or use.

The resident's most recent assessment completed several weeks prior to his death, indicated he had difficulty breathing and was sent to the hospital. He was diagnosed with pneumonia started on antibiotics. The resident's care plan was updated to include rest and increase fluids.

During an interview, the nurse stated the resident could come and go as he wanted. The nurse stated there was no indication he was using drugs at the facility.

The police report indicated a staff member stated to police that safety checks were performed every two hours, but the resident would become combative or yell at staff to leave him alone. The report noted the resident had a history of being a person in crisis as well as drug and alcohol use.

The resident's death certificate indicated the resident's cause of death was due to fentanyl and methamphetamine toxicity and pneumonia contributing. The manner of death was an accident.

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: No family contact available.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The resident was assessed to be at risk for chemical abuse. Facility staff activated emergency services when the resident was found unresponsive.

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
	36794	A. BUILDING: _____ B. WING _____	C 05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3647 NORTH 6TH ST. MINNEAPOLIS, MN 55412

(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 May 3, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL367946553C/#HL367949026M. No correction orders are issued.	0 000		