Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368022400M
Compliance #: HL368021551C

Date Concluded: July 18, 2024

Name, Address, and County of Licensee Investigated:
Care Plus Home Care LLC
2860 132nd Ave NW
Coon Rapids, MN 55448
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Lisa Coil, RN, BSN, 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 resident #1 and resident #2 when staff failed to provide supervision and monitoring for the residents. Resident #1 and resident #2 left the facility without staff knowing, rented a hotel room, and had sex. Resident #2 returned to the facility two days later. It is unknown when resident #1 returned to the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Resident #1 and resident #2's care plan was followed. Staff members called and informed administration, resident #1's guardian, resident #2's case worker, and notified law enforcement of the missing residents. Resident #1 and resident #2 left the facility for one night and returned safely the next day.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator interviewed resident #1 and resident #2's case worker. The

investigation included review of the resident record(s), facility incident reports, and related facility policy and procedures.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included mental health diagnoses. Resident #1's service plan included reminders with daily living, managing behaviors, and medication management.

Resident #1's assessment indicated resident #1 was oriented, able to understand, and had a guardian who had decision-making authority. The assessment indicated resident #1 had a history of elopement and did not wander. The assessment further indicated resident #1 did not have restrictions regarding visitors, social participation, or personal privacy.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included mental health diagnoses. Resident #2's service plan included reminders with daily living, managing behaviors, and medication management.

Resident #2's assessment indicated resident #2 was oriented and able to understand. The assessment further indicated resident #2 was not at risk for elopement. However, the assessment did indicate resident #2 paced and wandered in the house and backyard and had eloped with another resident out into the community.

An incident report indicated resident #1 spent a lot of time trying to convince resident #2 to leave the facility. Resident #1 and resident #2 went outside to smoke and walked off the facility premises late one evening. The report indicated staff members notified facility administration; the administration notified resident #1's guardian, resident #2's case worker, and the police of the incident.

During an interview Resident #1 stated she was under guardianship. Resident #1 stated she left the facility with resident #2, took a ride share company to a hotel, and spent the night watching television just to get out of house for a night. Resident #1 stated she did not inform staff she was leaving and did not sign out. Resident #1 stated she returned to the facility the following day. Resident #1 denied having sexual relations with resident #2. Resident #1 stated her guardian told her to let staff know when she leaves the facility and to not leave the facility without staff following the incident.

During an interview Resident #2's case manager stated resident #2 was no longer under commitment and could make his own decisions. Case manager stated she had received a voicemail from staff which said resident #2 had left the facility with resident #1 one night. Case manager stated she sent a text message to resident #2 and he responded by saying he had stayed at a hotel, he was safe, and he would be returning to the facility. Case manager stated she went to visit resident #2 about the incident and resident #2 said he and resident #1 had sex but did not want to discuss it further. Case manager stated she had conversation with resident

#2 about making safe choices and told him he should not leave the house without informing staff where he was going or without signing out.

During an interview, an administrative staff stated she had been at the facility into the evening shift and before leaving she had left, she asked resident #1 if she needed medication related to elevated activity, resident #1 declined medication. Administrative staff left and later received a one phone call from staff saying resident #1 and resident #2 were trying to leave the facility and another phone call stating resident #1 and resident #2 had left the facility. Administrative staff stated she informed resident #1's guardian and resident #2's case manager/probation officer the resident's had left the facility. Administrative staff arrived at the facility early the following morning and the residents still had not returned, so she called the police and filed a report. Administrative staff stated both residents returned safely to the facility before noon.

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: Resident #1, yes. Resident #2, declined.
Family/Responsible Party interviewed: Resident #1, attempted. Resident #2, yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff attempted to contact resident #1 and resident #2. The facility staff informed the necessary people and notified law enforcement of the missing residents.

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
	36802	A. BUILDING: _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	2860 132ND AVENUE NW COON RAPIDS, MN 55448

(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 12, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL368021551C/#H368022400M. No correction orders are issued.	0 000		