

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL369983782M;  
HL369983963M

**Date Concluded:** October 7, 2024

**Compliance #:** HL369984231C; HL369984624C

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

### **Investigated:**

Nest Care  
3930 Zane Ave N  
Robbinsdale MN 55422  
Hennepin County

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

**Evaluator's Name:** Peggy Boeck, 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 resident #1 when they failed to ensure resident #1 received his medications, which led to psychiatric decline and hospitalization.

Also, the facility neglected to supervise resident #2, who obtained street drugs, overdosed in the facility, which led to hospitalization.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect of resident #1 was not substantiated. The facility worked with resident #1's community providers to facilitate psychiatry appointments and medication as resident #1 allowed. Resident #1 independently chose to not take medications which led to increased psychiatric symptoms and hospitalization.

The Minnesota Department of Health determined neglect of resident #2 was not substantiated. The facility worked with resident #2's community providers to ascertain the level of supervision resident #2 required as his own guardian. Resident #2, when given increase of privileges outside of the facility, used his time to obtain and use street drugs. Resident #2 returned to the facility and lived there successfully for several months until he chose to self-discharge.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted community providers for both resident #1 and resident #2 as well as local law enforcement. The investigation included review of the residents' records, hospital records, facility incident reports, personnel files, staff schedules, staff behavioral health training, law enforcement reports, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

Resident #1 lived in an assisted living facility. Resident #1's diagnoses included bipolar disorder, manic with psychosis. Resident #1's service plan included assistance with reminders for hygiene, meals, housekeeping, laundry, and behavior management. Resident #1's assessment indicated his behaviors included agitation, anxiety, physical aggression, and verbal aggression. The assessment included staff direction to redirect using learned communication skills, anticipated triggers, remove others from area, and allow for calming in a separate space.

Resident #1 came to the facility from the hospital on no medications and with independent decision making. The facility worked with his case managers (CADI and mental health) to arrange appointments with psychiatry to initiate medications. Resident #1 cancelled the first appointment when he saw the provider on video. Resident #1 began to show increased symptoms of hallucinations, agitation, verbal, and physical aggression, which required law enforcement interventions, as well as the mental health mobile crisis team interventions multiple times. Resident #1 agreed to an appointment with a new provider in person a few weeks later. The psychiatric provider prescribed an anti-psychotic medication, but resident #1 refused to take it, as well as an as needed (PRN) anti-anxiety medication. Staff documented his refusals in service notes.

One day a manager drove resident #1 to look at a new facility (as they were having difficulty managing his behaviors) and on the way home resident #1 grabbed the steering wheel with intent to crash. Upon returning home the manager called the mental health mobile crisis team and law enforcement. After much discussion, resident #1 was placed on a transport hold and taken to the hospital, where a court commitment with medication was pursued and obtained. Resident #1 discharged to another assisted living facility from the hospital three weeks later.

Resident #2 lived in an assisted living facility. Resident #2's diagnoses included post-traumatic stress disorder, schizoaffective disorder, and methamphetamine abuse. Resident #2's service plan included assistance with reminders for hygiene, meals, housekeeping, laundry, medication management, and behavior management. Resident #2's assessment indicated he received an injectable anti-psychotic medication once per month, which he cooperated with.

One day staff noted resident #2 had exercised his new privilege to leave the facility for short periods. Resident #2 returned and went into his room. Staff attempted a safety check and could not enter resident #2's room as he blocked it. Staff called law enforcement, who forced open the door and found resident #2 unresponsive. An ambulance transported resident #2 to the hospital where it was determined that he overdosed on street drugs. Due to severe agitated delirium, the hospital sedated resident #2 for two days. When awakened after the third day, the hospital discharged resident #2 back to the facility.

Resident #2 continued his medications and enjoyed his privileges. Two months later he informed the facility that he was leaving, made a connection with a shelter, and self-discharged.

During an interview, a manager stated resident #1 showed no mental health symptoms for the first five or six days, but then got more aggressive and out of touch with reality every day. The manager stated the facility had concerns that they would not be able to manage his symptoms and began searching for a new placement.

During investigative interviews, multiple staff members stated resident #1 was aggressive verbally and although he never struck anyone, he constantly threatened to harm them.

During interview, resident #2's case managers (CADI and mental health) stated resident #2 progressed well at the facility (apart from the overdose) due to the stable environment and supportive staff. The case managers stated the resident made his own decisions and he told them he did not like authority figures. The case managers stated they had a plan for resident #2 and had high hopes for his success, but expressed concern that as he spent time in the community, he likely began to use street drugs again, but was at his baseline when he decided to self-discharge.

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 -resident #1 attempted, resident #2 was not found.

**Family/Responsible Party interviewed:** No family members identified.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

The facility reviewed and anticipated adjusting their admission policy to include gathering more information prior to admission.

**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>36998</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEST CARE INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3930 ZANE AVENUE NORTH ROBBINSDALE, MN 55422</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 18, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL369984231C/#HL369983782M, #HL369984624C/HL369983963M. No correction orders are issued.</p>	0 000		

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