Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370017605M
Compliance #: HL370014267C

Date Concluded: September 13, 2023

Name, Address, and County of Licensee Investigated:
Multicultural Care Center, LLC
3654 2 1/2 Street Northeast
Minneapolis MN, 55418
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility and individual 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 a resident when they failed to provide supervision which resulted in the resident using drugs. The staff found the resident deceased in his room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the alleged perpetrators (AP 1 and AP 2) were responsible for the maltreatment. The facility and AP 1 failed to ensure the resident received person centered, individualized care based on his medical needs. Additionally, AP 1 changed the physician's order for Suboxone (a medication to treat opioid addiction) without orders from a physician to do so. AP 2 failed to provide care services and observe the resident for over ten hours prior to finding him deceased.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the physician, law enforcement, and case workers. The investigation included review of resident records, and law enforcement

reports. Also, the investigator toured the facility and observed interactions between staff and the current resident at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included substance abuse, depression, bipolar disorder, and borderline personality disorder. The resident had a history of abusing himself and recurrent relapses of drug use.

Hospital records indicated the resident required multiple inpatient hospital stays for depression and suicide attempts. The resident reported he was thinking about overdosing on Fentanyl or jumping in front of a train. The resident also had an addiction to opiate medications (pain pills). The resident had a physician order for Suboxone three times a day, to help reduce cravings for opiate medications and manage the feelings of withdrawal from them. The resident was to follow up with his physician monthly to obtain Suboxone. After the resident received care from the hospital, he moved to an inpatient psychiatric facility, then to the assisted living facility.

The facility's Uniform Disclose of Amenities and Services included safety checks by staff up to every 15 minutes as a service that could be provided.

The resident's service plan included assistance with medication administration, housekeeping, laundry, safety checks twice daily, behavior management twice daily and socialization twice daily. The resident's nursing admission assessment, completed by AP 1, indicated the resident had suicidal and homicidal ideation. The resident's care plan, created by AP 1, indicated the resident had a history of drug use and relapses, therefore he needed staff supervision, continuous support, and education on consequences of drug use to stay sober. The care plan indicated there would be awake staff 24 hours a day, and staff would monitor for signs and symptoms of the resident being under the influence of substances. The care plan lacked duration and frequency for staff monitoring. AP 1 failed to implement adequate frequency of safety checks for the newly admitted resident with suicidal and drug use risk who discharged from an inpatient psychiatric facility.

In addition, there was a lack of a consistent documentation system for unlicensed personnel to document services were provided. Unlicensed personnel occasionally would document in a written note what services were provided in the service delivery records.

The resident's medication administration record (MAR) in the month prior to his death, indicated the resident did not receive Suboxone the entire month. The next month, AP 1 changed the Suboxone order from being scheduled three times a day to "as needed" without a physician order. There was no documentation AP 1 contacted the physician to communicate refusals of medication by the resident or any medication order change requests. The month of the resident's death, the resident did not receive any Suboxone. Clinic records indicated the resident had one scheduled appointment with his physician one week after his admission to the facility. The facility failed to ensure the resident had seen his physician once a month as directed during the three months the resident resided at the facility.

Service delivery records lacked any documentation services were provided including safety checks, behavior management, laundry, or housekeeping, for four days prior to the resident's death. The MAR indicated the resident did not receive any of his scheduled medications two full days prior to his death.

The morning of the resident's death, his MAR indicated he did not receive his morning medications, due to "refusal" as documented by AP 2. The facility incident report indicated AP 2 went to the resident's room to give him his bedtime medications and saw he was unresponsive. AP 2 called the AP 1, who then instructed her to call emergency services (911).

Law enforcement records indicated emergency responders found the resident deceased in his bed. The responders located drugs and drug paraphernalia with the resident. AP 2 stated she did not see or interact with the resident for her entire shift.

The medical examiner report indicated the resident's death was due to fentanyl and methamphetamine toxicity.

During an interview, the mental health counselor from the inpatient psychiatric facility stated she spoke directly to AP 1 prior to his discharge and admission to the facility about the care needs he required.

During an interview, AP 1 said she went to the inpatient psychiatric facility to assess the resident prior to accepting him into the assisted living facility. AP 1 said she was aware of his need for mental health cares and his history of drug use, but said staff had never seen him using drugs. AP 1 said she never had any conversations with the resident's physician while he was at the facility. AP 1 said she was unsure if the resident went to see a physician during the time he was at the facility but said had he seen the physician she would have known due to receiving orders from the pharmacy. AP 1 said the pharmacy did not send any new medications to the facility for the resident while he lived there. AP 1 said she looked at the documentation in the MAR and saw there were discrepancies, however she asked the resident if he received his medications and he always said, "yes." AP 1 said the resident told her to change Suboxone to "as needed", as opposed to scheduled three times daily as directed by the physician. AP 1 said she did not talk with the physician prior to doing this. The day of the death, AP 1 said she received a call from AP 2 worried because she had not seen him all day. AP 1 said AP 2 got a key to open the resident's door and found him unresponsive. AP 1 directed AP 2 to call 911. AP 1 said AP 2 should have checked on the resident during her shift because there was a medication (gabapentin) the resident should have received three times during the day. AP 1 said AP 2 told her she thought the resident was sleeping and he would get upset if she woke him up.

AP 2 declined interview.

During consultation with medical providers, the resident had one appointment with a physician during the time he lived at the facility, and he attended the appointment alone. The resident also went to the emergency room for worsening depression and abdominal pain approximately two months prior to his death. The current physician order for Suboxone was for staff to give it to him three times a day.

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:
(a) 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: Yes.
Alleged Perpetrator interviewed: AP 1 Yes., AP 2 No, Declined.

Action taken by facility:
The facility provided education to staff.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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
MN Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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 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: #HL370014267C/#HL370017605M On August 14, 2023, through August 15, 2023, 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 was one resident receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL370014267C/#HL370017605M, tag identification 470, 1640, 1690, 2310, 2360.	0 000	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 License Providers. 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 surveyors' 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=D	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to ensure staff were awake 24 hrours per day, seven days per week to provide care for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
0 470	Continued From page 2 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: On August 14, 2023, at 9:00 a.m. surveyor arrived at facility and waited for staff to respond to let her inside. Unlicensed personnel (ULP)-E opened the door for surveyor after surveyor rang the door bell a few times. ULP-E appeared to have just woken up, however denied sleeping. Once surveyor entered facility, ULP-E went upstairs and removed bedding from the couch in the living area. ULP-E fixed pillows on couch and surveyor observed ULP-E rearranging the couch area. There was only one resident at the facility (R2) upon surveyor arrival and surveyor observed R2 sleeping in her bed, in her room. On August 14, 2023, at 12:49 p.m., surveyor spoke to owner (OW)-A to observe video footage from night prior to confirm if ULP-E was sleeping. On August 14, 2023, at 12:57 p.m., OW-A said ULP-E was sleeping on the couch prior to surveyor arrival. On August 15, 2023, at 10:00 a.m., OW-A said ULP-E was sleeping for "a long time". OW-A said ULP-E woke up at 3:30 a.m., but OW-A did not want to add further information. OW-A confirmed staff should be awake and not sleeping. Time period for correction: seven (7) days	0 470		
01640 SS=J	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01640	Continued From page 3 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement mental health services and safety checks for one of one resident (R1) reviewed. R1 admitted to licensee after discharge from a stay at an inpatient mental health facility for suicide ideation including thoughts of overdosing on fentanyl. Law enforcement observed the resident to be deceased with three baggies of suspected narcotics, two glass drug paraphernalia containing residues, and a jar containing green leafy substance in his possession. Staff had not observed the resident for approximately 12 hours. This practice resulted in a level four violation (a	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01640	Continued From page 4 violation that results in 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's pre-admission history hospital records dated November 15, 2022, indicated the resident had a psychiatric inpatient stay due to suicidal thoughts. The resident had a history of suicide attempts and required hospitalization eight times over a period of twenty years. The records indicated opiate were the resident's "drug of choice" and he required suboxone for opiate addiction. R1's pre-admission mental health intermediate care facility discharge record dated April 26, 2023, indicated R1 had an extensive mental health history including suicidal ideation that were recurrent and he required multiple hospitalizations. R1's diagnoses included alcohol and substance abuse disorders. The record indicated R1 should meet with his physician monthly and continue to obtain suboxone medication. The notes indicated R1 should meet with his psychiatrist monthly. The record indicated registered nurse (RN)-B was aware of R1's mental health history and could provide R1's care needs. R1 admitted to the licensee April 26, 2023. R1's diagnoses included anxiety, substance abuse, depression, bipolar disorder, and borderline personality disorder. R1's admission assessment dated April 26, 2023, indicated R1 required monthly physician visits.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01640	Continued From page 5 The assessment indicated R1 had a history of suicidal and homicidal ideation and he had a history of drug use with relapses. R1 had poor judgement and refused medications. R1's care plan dated April 26, 2023, indicated R1 had a history of drug use and relapses, and he needs staff supervision, continuous support and education on consequences of drug use to stay sober. The care plan indicated there would be awake staff 24 hours a day, and staff would monitor for signs and symptoms of R1 being under the influence of substances. The care plan lacked duration and frequency for staff monitoring. R1's service plan, not signed, no date, but effective date August 15, 2023, indicated the resident required medication administration three times a day, safety checks twice daily, behavior management twice daily, and socialization twice daily. R1's service plan lacked any meal service. R1's service plan remained unchanged since admission. R1's service plan lacked supervision services appropriate for a newly admitted resident from an inpatient mental health facility stay for suicidal ideation and drug abuse. R1's clinic record dated May 25, 2023, indicated he went to the emergency room for abdominal pain and increased depression symptoms. R1's record lacked implementation or increased services to meet his needs for mental health care. The facility response for supervision and interventions was unchanged from admission. R1's service delivery record lacked consistent	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01640	Continued From page 6 documentation about the services staff provided to R1. The record indicated staff provided two narrative notes for May 2023, then five narrative notes for June 2023. The record lacked documentation staff provided services listed in R1's service plan. In July 2023, there were two narrative notes, however there was documentation of some services staff provided which included behavior management for agitation, anxiety, and verbal aggression but there were only eight days staff documented they provided those services. In addition, staff documented they completed safety checks only one day in July which was four days prior to the resident's death. There were no narrative notes, or documentation of services provided to the resident four days prior to his death. Law enforcement record dated July 28, 2023, at 10:00 p.m., indicated they responded to unlicensed personnel (ULP)- E's call for assistance and found R1 was deceased. A report indicated ULP-E did not interact, talk, or see R1 her entire shift. Law enforcement located three baggies containing suspected narcotics, two glass drug paraphernalia containing residues, and a small jar containing green leafy substance. Uniform Disclosure of Assisted living Services and Amenities (UDALSA) dated June 20, 2022, indicated licensee could provide security and monitoring service that included safety checks as frequently as every 15 minutes. The UDALSA indicated licensee would provide three meals per day plus snacks. On August 17, 2023, at 10:35 a.m., R1's mental health counselor (MHC)-C said she spoke directly to RN-B prior to R1's discharge about his care needs.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01640	Continued From page 7 On August 18, 2023, at 1:11 p.m., RN-B said she went to the mental health institution to meet with R1 and assess him prior to accepting him into the facility. RN-B said she met with his care team and decided he could move in. RN-B said R1 required care for his mental health, but was physically independent. RN-B said R1 got agitated quickly and had behaviors of not wanting staff around his room. RN-B was aware of R1's history of drug use but was not aware of any problems while at the facility. RN-B said staff monitored him for drug use and staff were trained on mental health and substance abuse. RN-B said staff were supposed to be awake 24 hours per day and monitoring R1 for drug use and self-harm. RN-B said staff monitored him at the start of their shift, and at the end of their shift. RN-B said staff work 12 hours shifts, but the facility is small, and they monitor him all the time. RN-B said ULP's get information on how to provide care to the residents from the service plan. RN-B said ULP-E should have checked on him periodically during her shift. RN-B said the resident should have had medication provided at least three times to him during the shift. RN-B said ULP-E said she did not check on him because she thought he was sleeping, and he would get upset if she woke him up. RN-B said after R1's death she told ULP's to do safety checks on all residents every two to three hours, but said ULP's do not document the safety checks. The licensee's policy titled Scope of Service dated April 22, 2022, indicated the licensee would provide nursing services to residents using a person centered planning and service delivery process in conjunction with its published UDALSA.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01640	Continued From page 8 TIME PERIOD OF CORRECTION: Seven (7) Days	01640		
01690 SS=J	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01690	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview, and document review, the licensee failed provide adequate medication management services to one of one resident (R1) reviewed. Registered nurse (RN)-B failed to communicate with the R1's physician to ensure medication orders were accurate and up to date. RN-B failed to monitor medication administration and report to R1's physician he missed dosages of his medications. In addition, RN-B changed suboxone to "as needed" without consulting R1's physician. R1 was found deceased with street drugs in his possession. This practice resulted in a level four violation (a violation that results in 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 licensee on April 26, 2023, after a four-month inpatient stay at a mental health institution. His diagnoses included anxiety, substance abuse, depression, bipolar disorder, and borderline personality disorder. R1's service plan, not signed, no date, but printed August 15, 2023, indicated the resident required medication administration, safety checks, behavior management, and socialization. R1's pre-admission history hospital records dated November 15, 2022, indicated the resident had a psychiatric inpatient stay due to suicidal thoughts. The resident had a history of suicide attempts and required hospitalization eight times over a	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01690	Continued From page 10 period of twenty years. The records indicated opiate were the resident's "drug of choice" and he required suboxone for opiate addition. R1's mental health inpatient records dated January 5, 2023, indicated R1 required Suboxone 8-2 milligrams (mg) sublingual film. The order read as follows: Place 1 film under tongue three times per day. R1's nursing assessment dated April 26, 2023, no time, indicated R1 required monthly physician visits. The assessment indicated the resident had a history of suicidal and homicidal ideation and he had a history of drug use with relapses. R1 had poor judgement and refused medications. R1's pharmacy record dated January 1, 2023, through August 17, 2023, indicated the order for suboxone 8 mg-2 mg was as follows: Place 1 film under tongue three times a day. In addition, the pharmacy was dispensing a quantity of 90, which would be a one-month supply if the licensee administered the medication as directed. The prescription order was dated May 8, 2023. The record also indicated they received an order for R1 to receive a Wegovy taper injection taper. Wegovy 0.25 mg injection taper read as follows: Inject 0.5 mg subcutaneously once per week for 28 days, then 0.5 milliliters (ml) subcutaneously once weekly for 28 days, then 0.75 ml subcutaneously once a week for 28 days. The taper order continued. The prescription order date was May 3, 2023. R1's medication list from the licensee, printed August 15, 2023, indicated R1 received Suboxone 8-2 mg. The order read as follows: Place 1 film under tongue three times a day. The order indicted the medication was "as needed."	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01690	Continued From page 11 R1's medication administration record (MAR) dated June 2023, indicated R1 was supposed to receive Gabapentin three times a day. The order read as follows: Gabapentin 300 mg, take three capsules by mouth three times daily. The MAR indicated R1 was supposed to receive the medication at 9:00 a.m., 4:00 p.m., and 7:00 p.m. The MAR indicated on June 23, 2023, the 7:00 p.m. time was changed to 9:00 p.m., however until then, R1 received the 7:00 p.m. dosage between the times of 7:32 p.m. to 10:06 p.m. Also, the 4:00 p.m. dosage was given between the times of 4:00 p.m. to 11:05 p.m. There were 15 days staff did not sign out they administered Gabapentin dosages. In total, there were 17 days staff failed to document they administered scheduled medications. R1 received no dosages of Suboxone in June 2023. R1's MAR dated July 2023, indicated Suboxone listed under the "as needed" category of medications. The order read as follows: Suboxone (daily) place 1 film under tongue three times a day. R1 received no dosages of the medication. The MAR lacked any identification of Wegovy transcription. The MAR indicated there were 48 missed dosages of medications throughout the month until R1 was deceased on July 28, 2023. The MAR also indicated staff documented medications as administered to R1 for two days after he was deceased. R1's MAR dated June 2023 and July 2023, also indicated R1 refused medications during these months. The MAR lacked documentation on follow up of R1's refusals. Law enforcement record dated July 28, 2023, at 10:00 p.m., indicated they responded to	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01690	Continued From page 12 unlicensed personnel (ULP)-E's call for assistance and found R1 was deceased. A report indicated ULP-E did not interact, talk, or see R1 her entire shift. Law enforcement located three baggies containing suspected narcotics, two glass drug paraphernalia containing residues, and a small jar containing green leafy substance. The medical examiner report dated August 7, 2023, indicated R1's cause of death was mixed fentanyl and methamphetamine toxicity. R1's primary medical clinic records received on August 17, 2023, indicated he had an appointment with his medical provider on May 3, 2023. The clinic records lacked any communication records from the facility. During an interview on August 18, 2023, at 1:11 p.m., RN-B said R1 admitted to the facility after he was at a mental health facility. RN-B said she received a list of his medications on a paper from the hospital. RN-B said she never communicated with R1's physician. RN-B said she did not know if R1 ever went to see his physician after admission to the facility. RN-B said if R1 went to his physician, she would know because the pharmacy would send them any new medications. RN-B said R1 specifically wanted suboxone "as needed", so she changed the medication to be administered "as needed." RN-B said she did not have any conversation with R1's physician before she changed the medication. RN-B said she was never aware of any order for Wegovy because the medication did not come to the house. RN-B said she looked at the MAR weekly and there were times ULP did not document they administered medication. RN-B said she asked R1 if he received his medications, and he told her he did. RN-B said the ULP's just	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37001	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL CARE CENTER LLC	3654 2 1/2 STREET NE MINNEAPOLIS, MN 55418

(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
01690	Continued From page 13 failed to document, and she told them it was unacceptable. RN-B said R1 never refused his medications and if he had missed more than three times, she would have notified R1's physician. The licensee's policy titled, Medication Administration dated December 6, 2022, indicated licensee would provide safe administration of medications by qualified personnel. TIME PERIOD FOR CORRECTION: Seven (7) Days	01690		
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 one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, the facility and an individual were responsible for the maltreatement, in connection with incident which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	