Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370514363M
Compliance #: HL370515342C

Date Concluded: August 26, 2024

Name, Address, and County of Licensee Investigated:
Amerigrace Home Care LLC
890 Clarence Street
Saint Paul, Minnesota 55106
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 the resident when the resident overdosed on unknown drugs in a bathroom twice within one month.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility did not know the resident started using illegal substances until the first overdose. After the first incident, facility staff increased how often they checked on the resident, encouraged the resident to seek treatment, and involved his case managers. After the second overdose, the facility changed the bathroom door handle, so they could unlock it if the resident did not respond to them while in the bathroom.

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

incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed the bathroom, resident's room, and how staff monitored the resident.

The resident resided in an assisted living facility. The resident's diagnoses included substance abuse. The resident's service plan included assistance with behavior management and safety checks. The resident's assessment identified the resident as being at risk to abuse himself with substances.

An incident report indicated staff found the resident on the bathroom floor and a syringe in the sink. The resident appeared unconscious with shallow breathing. The staff member administered naloxone (a medication used to treat a known or possible opioid overdose), and the resident immediately regained consciousness. After the incident, a staff member spoke with the resident who stated he got up from the toilet, felt lightheaded, and sat on the floor. The resident denied injecting drugs, stating he used the syringe on the blister on his foot. The staff member recommended the resident go to the hospital for evaluation, but the resident declined. The facility placed the resident on temporary safety checks every 15 minutes and scheduled an appointment with his provider.

A progress note one week after the first overdose indicated a nurse attempted to have another conversation with the resident about his substance use and seeking treatment, but the resident declined going to treatment.

After another week, a progress note indicated the facility held a care conference with the resident and his case managers. Facility staff again encouraged treatment or other supportive options, but the resident declined.

Progress notes indicated facility staff monitored the resident throughout each shift daily. These progress notes did not identify any additional substance use concerns between the two overdoses.

A second incident report less than four weeks later indicated a staff member found the resident locked himself in the bathroom for over an hour. The staff member tried knocking on the door and calling the resident's phone, but he did not open the door. The staff member called the nurse who instructed the staff member to call 911. When law enforcement arrived, they got the door open and found the resident in the bathroom with a used syringe. After law enforcement and emergency medical services left the facility, the resident agreed to go to the emergency department for evaluation. The facility changed the lock on the door, so staff could open it from the outside if the resident locked himself in the bathroom again, notified the resident's family, provider, and case managers, and placed the resident on hourly safety checks while awake.

The resident's hospital records indicated the resident remained in the hospital for observation for about five hours. Hospital staff noted no concerns during this time. The hospital discharged the resident back to the facility in stable condition.

Progress notes indicated a nurse updated the resident's psychiatrist and family and attempted to schedule a therapy appointment after the second overdose occurred. The facility staff also continued to monitor the resident each shift daily and document progress notes.

During investigative interviews, multiple staff reported the resident had not overdosed before or after the two overdoses.

During an interview, a nurse stated the resident had not been using drugs upon admission. Since he had a history of substance use, they included an intervention to monitor him for signs of use. After the first overdose, the nurse instructed staff to monitor him closely for signs of use. This overdose had been the first time they saw him use drugs while at the facility. After the second overdose, the nurse put the resident on hourly safety checks and talked him into going to the emergency department. The nurse also held training to ensure all staff knew how to administer naloxone. Since these two incidents, the resident has not had any more overdoses.

During an interview, one of the resident's case managers stated the facility held a conference with the resident, case managers, and staff, after the resident's first overdose. The facility staff seemed like they were really trying to help and support the resident. The facility also maintained good communication with the case manager regarding the resident.

During an interview, the resident stated he had a long history of substance abuse but had not been actively using at the facility until he started experiencing mouth pain related to rotting teeth. To deal with the pain, the resident started using drugs again. Since then, he had his teeth pulled, and the pain has gotten better. He stated he no longer had a desire to use illegal substances. The resident stated his life improved a lot living at the facility.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility administered naloxone after the first overdose and called 911 after the second overdose. The facility closely monitored the resident and increased safety checks. The facility also continued to encourage the resident to attend therapy, treatment, or narcotics anonymous.

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
	37051	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERIGRACE HOME CARE LLC	890 CLARENCE STREET SAINT PAUL, MN 55106

(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 August 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL370515342C/#HL370514363M. No correction orders are issued.	0 000		