*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL371023544M
**Compliance #:** HL371023850C

**Date Concluded:** October 31, 2024

**Name, Address, and County of Licensee Investigated:**
Nuvision Homecare Services LLC
4568 Zenith Avenue North
Robbinsdale MN 55422
Hennepin County

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

**Evaluator's Name:** Holly German, 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 they failed to supervise the resident's use of alcohol, placing the resident at risk for harm.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent with decision making, with no legal guardian. The resident would leave the facility and partake in drinking alcohol off facility property to the point of inebriation. The facility assisted the resident as needed upon his return, communicated with his medical providers, encouraged alcohol treatment, and provided medications as ordered. The resident declined alcohol treatment.

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

and related facility policy and procedures. Also, the investigator observed staff and resident interactions while on site.

The resident resided in an assisted living facility. The resident's diagnoses included alcoholism and post-traumatic stress syndrome. The resident's service plan included assistance with behavior management and medication administration. The resident's assessment indicated the resident was alert and oriented and walked independently.

The resident admitted to the facility from an alcohol treatment facility under a court order. The resident was his decision maker, with no legal guardian, who frequently signed himself out of the facility during the day. The resident frequently returned to the facility inebriated from excessive alcohol use. While inebriated in the community, the resident required law enforcement assistance to aide with his behaviors and return to the facility. Despite encouragement from facility staff and recommendations from medical providers, the resident declined to submit to alcohol treatment and continued to drink alcohol excessively while out in the community.

The resident's medication administration record indicated the resident received a Vivitrol (a medication used to treatment alcohol dependence) injection monthly.

The resident's individual abuse prevention plan indicated the staff monitored the resident for signs of being under the influence such as slurring words, smelling of alcohol, and staggering when walking. When under the influence, staff were directed to complete a room check as the resident allowed, complete safety checks every two hours, redirect the resident in a calm manner and called 911 if necessary. The plan directed staff to call COPE (a mobile crisis response team) if the resident was aggressive while intoxicated and interventions to calm the resident were ineffective.

During an interview, the nurse stated the facility attempted to continue the breathalyzer testing the resident's previous facility did, but the resident refused to do them. The nurse stated they offered the resident assistance with attending alcoholics anonymous and getting into another treatment facility, but the resident declined. The nurse stated the staff checked on the resident every two hours and did not find alcohol in his room or in the facility. The nurse stated the resident left the facility to go out in the community about every other day and returned inebriated, belligerent, and verbally aggressive. The nurse stated the facility staff, the resident and his community support staff had regularly scheduled meetings to go over his care, but the resident refused all recommendations. The nurse stated when the resident returned to the facility inebriated, the staff assisted him to his room as needed, took his vital signs, and gave him his medications as his doctor had directed to do.

During an interview, the facility administrator stated the facility staff constantly reminded the resident of the alcohol resources available to him, but the resident refused, stating he was his own man and will do what he wants to. The administrator stated staff had never caught the

resident drinking in the facility. The administrator stated they had identified speaking too much to the resident when he returned to the facility inebriated was a trigger that would make the resident become aggressive. The staff ensured he was safe, offered food and water, and left him alone if he was not bothering anyone. The administrator stated it was not plausible to notify the resident's doctor every day when the resident became inebriated, but they did keep the doctor updated on the resident's drinking problem at his regularly scheduled appointments. The nurse reviewed and initiated any new orders provided.

During an interview, the resident's case manager stated facility staff had reported to him the resident's behavior problems, coming home drunk and the many law enforcement reports. The case manager stated the resident was placed on 72 hour holds at the hospital for his drinking multiple times. The case manager stated the resident met with his other community staff support person one to two times a week, and felt the facility was probably doing the best they can with the resident.

During an interview, the resident stated he had a drinking problem in his past, but not currently. The resident stated he goes out into the community all the time, and it was his business what he does when he leaves the facility. The resident stated he only had law enforcement called on him once a long time ago for trespassing. The resident declined needing alcohol treatment.

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**: No, resident was his own person.
**Alleged Perpetrator interviewed**: Not applicable.

**Action taken by facility:**
The facility monitored the resident for symptoms of being under the influence, provided safety interventions, communicated with his care team and physician. The facility administered the

resident's monthly injection for alcohol abuse. The facility offered assistance in obtaining alcohol treatment.

**Action taken by the Minnesota Department of Health:**
No further action 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 |
|---|---|---|---|
| | 37102 | A. BUILDING: _____ B. WING _____ | C 10/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NUVISION HOMECARE SERVICES LLC | 4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422 |

| (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<br><br>On October 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL371023850C/#HL371023544M . No correction orders are issued. | 0 000 | | |