Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371048466M
Compliance #: HL371045687C

Date Concluded: May 29, 2024

Name, Address, and County of Licensee Investigated:
GreaterCare Facilities, LLC
2087 Woodbridge Way
Woodbury, MN. 55125
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal RN, BSN
Special Investigator

Finding: Substantiated, facility 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 the resident when facility staff failed to ensure the resident took medication as prescribed. The resident hoarded medication, overdosed, and was hospitalized. In addition, the resident traded his prescription medications with staff for other medications not prescribed to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although the facility assessment directed staff to observe the resident taking his medication, the resident stockpiled medication in his room, overdosed, and required hospitalization.
The additional concern regarding the resident and staff trading prescriptions was reviewed. There were no specific staff identified, and no residents were taking the medication the allegation identified as being traded with the resident.

The investigator interviewed facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospital staff, case managers, and the resident's family. The investigation included a review of the resident facility record, hospital records, facility internal investigation, staff schedules, staff training, and related facility policy and procedures. Also, the investigator observed facility staff provide medication administration and care to other residents.

The resident resided in an assisted living facility with diagnoses including traumatic brain injury, autism spectrum disorder, attention deficit hyperactivity disorder, and disruptive mood dysregulation disorder. The resident's service plan included assistance with medication administration, behavior management, safety checks, daily housekeeping, and meals.

The resident's assessment directed staff not to leave the medication with the resident, even if the resident assured staff, he would take the medication later. Staff were directed to stay in the room until the resident swallowed the medicine. In addition, the assessment indicated the resident did not always take his medication when out of the facility; however, staff were directed to set up the resident's medications and send them with the resident when away from the facility.

A facility Incident Report indicated a family member notified the facility staff that the resident text messaged the family indicating he planned to end his life by taking a lot of pills that he had saved over the past several days. Staff members indicated the resident was found in his room "acting normal." However, staff observed the resident's room in disarray, including random medications on the floor. Staff members called 911, and the resident was transported to the hospital for evaluation.

Emergency department (ED) records indicate the resident arrived at the ED for crisis and overdose evaluation. The resident reported he took excessive amounts of ibuprofen, Adderall (stimulant), and other unknown medication. Toxicology records indicated symptoms were clinically mild and consistent with ibuprofen overdose. No alcohol, Adderall, or gabapentin was noted on the toxicology report

During interview leadership indicated there was no concern with the resident's ability to self administer medication when outside of the facility.

During interview a staff stated the resident did not allow staff members in the resident's bedroom, therefore, staff did not know if the resident took his medication. In addition, when the resident was away from the facility, the staff would prepare medication for the resident to take, but the staff was unsure if the resident took the medication while out.

During interview leadership stated the facility could not restrict the resident's rights and the facility had no options for management of the resident behaviors when outside the facility or when in his bedroom because the resident had rights. The facility reported concerns with managing the needs and safety of the resident while respecting rights and autonomy.

During interview a case manager stated the resident, family, and outside providers met for a meeting at the facility following hospitalization, and the resident's room was observed with medications on the floor, under the bed mattress, behind furniture, and scattered on the floor. During the meeting the decision was made the facility was unable to provide safe care for the resident and the family discharged the resident from the facility and did not return.

During interview a family member stated the resident made a 180% change when he moved into the facility and became a different person.

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 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, attempts made were unsuccessful.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility called 911, investigated the incidents, staff retraining for medication administration.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY WOODBURY, MN 55125

(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 ******ATTENTION****** 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: #HL371045687C /#HL371048466M On April 17, 2024, 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 were 3 residents receiving services under the provider's Assisted Living License. The following correction order is issued for #HL371045687C /#HL371048466M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	