Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371933861M
Compliance #: HL371934329C

Date Concluded: October 22, 2024

Name, Address, and County of Licensee Investigated:
Sakinah Homes LLC
120 Frost St E 1
South Saint Paul, MN 55075-3242
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela
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, on three occasions, after the resident went for a walk and did not return to the facility s and the facility did not know the resident's whereabouts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident eloped from the facility on three separate locations, facility staff followed policies and procedures and the resident's plan of care at the time the incidents occurred. Following each elopement, law enforcement was contacted and when found, the resident was transported to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's case worker. The investigation included review of the resident record(s), hospital

records, facility incident reports, personnel files, staff schedules and related facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and intellectual disability. The resident's service plan included assistance with bathing, grooming, shopping, meal preparation, medication management, making appointments, and behavior monitoring three times per day. The resident's community support plan indicated the resident could have fifteen-minute intervals of independence in the community.

The resident's assessment indicated the resident's cognition was intact. The assessment indicated the resident had a history of illegal drug use, anxiety, agitation, physical aggression, verbal aggression, repetitive behaviors, hallucinations, and delusions. The resident's nursing assessment directed staff to monitor the resident's whereabouts every fifteen-minutes, transport the resident to all appointments, redirect behaviors, encourage the resident to express feelings, and encourage the resident to make safe choices in decision making.

The resident's medical records indicated the resident eloped three times over a one-month period. Prior to each elopement, the resident was outside of the facility smoking in the designated smoking area or going for a walk in the neighborhood.

The resident's first elopement occurred when the resident went out for a walk to a fast-food restaurant nearby and did not return after fifteen minutes. The resident was found two days later at a family member's residence and returned to the facility.

The resident's second elopement occurred when the resident went for a walk and did not return to the facility. Facility staff and law enforcement conducted a search and when the resident was found, he was transported to the hospital for a mental health and chemical dependency evaluation. The resident returned to the facility the next day and facility staff communicated with the resident's case manager to explore treatment program options.

The resident eloped a third time and was found seven days later at a family member's residence. The resident was transported to the hospital for a mental health and chemical dependency evaluation.

The resident was hospitalized for one week and returned to the facility after being enrolled in an outpatient treatment program. Upon return the facility, the resident's plan of care was updated to include additional staff monitoring, supervision, and interaction with the resident.

During an interview, the resident recalled the three elopements and admitted he did not tell staff when he left the facility. The resident stated he used illegal drugs after eloping the first two times. The resident stated he eloped because he missed his family and wanted to visit

them. After the elopements, the resident was told he needed to be supervised when leaving the facility and staff now provided transportation to and from an outpatient treatment program.

During an interview, facility administrative staff stated the resident did not always inform staff of his whereabouts, but after the second elopement, the resident's walks were supervised by facility staff.

During an interview, facility management staff stated after the first elopement, the facility installed a doorbell that would ring if the door was opened. After the second elopement, the facility and the resident's case manager met to discuss options to enroll the resident into a treatment program.

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
Responsible Party interviewed: No, the responsible party declined to interview.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility staff contacted law enforcement and the resident's responsible party after each elopement and interventions were implemented to mitigate further risk for elopement.

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
	37193	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAKINAH HOMES LLC	120 EAST FROST STREET S ST PAUL, MN 55075

(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 #HL371934329C/#HL371933861M On August 30, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider. No correction orders are issued.	0 000		