



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371974103M

Date Concluded: January 31, 2023

Compliance #: HL371976875C

Name, Address, and County of Licensee

Investigated:

Unique Homes
3940 46th Avenue North
Robbinsdale, MN 55422
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN

Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

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 to supervise two residents when one of the residents overdosed on unknown street drugs in the facility, and the next morning a second resident overdosed on unknown street drugs and died. It is alleged that staff were sleeping at the time of the second overdose.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to implement staff interventions or follow-up with a nurse after the first resident (Resident #1) overdosed in the second resident's (Resident #2) room. Several hours after Resident 1 overdosed; Resident #2 overdosed and died. A facility staff stated the night staff was sleeping when they discovered Resident #2 unresponsive and not breathing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the medical examiner, and family. The investigation included review of law enforcement reports, hospital records, resident records, personnel files, facility incidents, documents, policies, and procedures related to assessments, incidents, and maltreatment of vulnerable adults. Also, the investigator toured the facility on the night shift and observed staff/resident interactions.

Resident #1 lived in an assisted living facility with diagnoses including bipolar disorder and substance use disorder. Resident #1's service plan included assistance with medication administration, meals, laundry, housekeeping, safety checks, and management of mental health symptoms.

Resident #2 lived in the assisted living facility with diagnoses including substance abuse and schizoaffective disorder. Resident #2's service plan included assistance with medication administration, meals, laundry, housekeeping, safety checks, and management of mental health symptoms. Resident #2's care plan directed staff to conduct room checks if staff suspected Resident #2 used illicit drugs and report to the nurse, who would assess the resident.

A police report indicated officers arrived at the facility one evening due to a 911 call about an unresponsive person. The report indicated when the officers arrived, they observed Resident #1 on the floor in Resident #2's bedroom, and Resident #2 was performing chest compressions on Resident #1. The officer located a pulse but Resident #1 was not breathing. The officer administered Narcan (an emergency rescue medication used to reverse an overdose of opioids). The report indicated the resident came to and the paramedics arrived and transported Resident #1 to the hospital.

A progress note indicated Resident #1 returned to the facility during the night.

A police report indicated the next morning officers arrived at the facility due to another 911 call for an unresponsive person. The report indicated the arriving officers found Resident #2 on a couch, not breathing. The report indicated officers began cardiopulmonary resuscitation (CPR), and when paramedics arrived, they took over life saving measures, which were unsuccessful. The medical examiner pronounced Resident #2 deceased. The report indicated a glass pipe used for smoking meth and a rolled-up dollar bill were found in Resident #2's room. The report indicated the two cases (Residents #1 and #2 overdose) were linked and follow-up would be done for both.

During an interview, a staff member stated Resident #2 called 911 and performed CPR on Resident #1 until police and paramedics arrived. The staff stated Resident #2 said Resident #1 had smoked marijuana and meth (methamphetamine).

During an interview, a staff member who found Resident #2 stated when she arrived for her morning shift, the night shift staff was asleep on the couch. The staff member stated she was

told by an administrative staff to misrepresent her reason for being at the facility on the day Resident #2 died, if asked. The staff member surmised it was because her “fingerprints did not come back yet” and did not have a background study clearance to work alone.

During an interview, an administrative staff stated the facility leadership had a meeting that included the nurse after Resident #1’s overdose. The administrative staff stated the facility implemented two-hour safety checks after Resident #1 returned to the facility but could not provide evidence of safety check completion.

During an interview, the nurse stated staff did not notify her of Resident #1’s overdose, and she did not participate in a meeting with facility leadership. The nurse stated she did not find out about Resident #1’s overdose until after Resident #2’s death.

In conclusion, 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: Resident #1 was interviewed, Resident #2 was deceased

Family/Responsible Party interviewed: Resident #1 declined to allow family contact; Resident #2’s family could not be reached.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility provided CPR training to staff.

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.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Robbinsdale City Attorney

Robbinsdale Police Department

Minnesota Board of Executives for Long Term Services and Supports

Hennepin County Medical Examiner

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2023
NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3940 46TH AVENUE NORTH ROBBINSDALE, 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL371976875C/#HL371974103M</p> <p>On January 17, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license.</p> <p>The following immediate correction order is issued for #HL371976875C/#HL371974103M, tag identification 0630.</p> <p>The licensee was notified of the immediate order (0630) on January 20, 2023 at 10:46 a.m.</p> <p>The immediacy of 0630 was removed on January 30, 2023, however, scope and severity remain at an J.</p> <p>The following correction orders which are not</p>	0 000	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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.</p> <p>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.</p>	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 immediate are issued for #HL371976875C/#HL371974103M, tag identification 0250, 0330, 2310, and 2360.	0 000		
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection,	0 250		

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0 250	<p>Continued From page 2</p> <p>survey, or investigation by the department;</p> <p>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;</p> <p>(11) refuses to initiate a background study under section 144.057 or 245A.04;</p> <p>(12) fails to timely pay any fines assessed by the commissioner;</p> <p>(13) violates any local, city, or township ordinance relating to housing or assisted living services;</p> <p>(14) has repeated incidents of personnel performing services beyond their competency level; or</p> <p>(15) has operated beyond the scope of the assisted living facility's license category.</p> <p>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on interviews and document review, the license failed to cooperate with and failed to provide accurate and truthful information during an investigation of two residents (R1, R2) reviewed for maltreatment. The licensee also violated a city ordinance related to housing by leasing the building from the owner in direct violation of city code. This had the potential to affect all residents and staff at the facility.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p>	0 250		

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0 250	<p>Continued From page 3</p> <p>Findings include:</p> <p>Failure to provide accurate staff information</p> <p>During an interview on January 17, 2023, at 8:06 a.m., assisted living director (ALD)-A stated a new staff, unlicensed personnel (ULP-H), had come to the facility to do paperwork, and discovered a resident (R2) unresponsive on December 13, 2022, when the staff had been employed by the licensee since October 5, 2022. was actually scheduled to work the 7:00 a.m. to 3:00 p.m. shift.</p> <p>During an interview on January 19, 2023, at 9:00 a.m. program manager (PM)-F stated ULP-H was not working on December 13, 2022, morning shift, but had only come in for paperwork.</p> <p>During an interview on January 19, 2023, at 3:25 p.m. ULP-H stated she had worked at the facility for several months and reported to the facility for work on December 13, 2022, at 7:00 a.m. for the morning shift. ULP-H stated she entered the unlit facility and found the night staff (ULP)-J asleep on the couch on the main floor, covered up with a blanket. ULP-H stated after the incident with R2's death, she received a call from PM-F who told her "if any one asks, just tell them that you were not at work, you just stopped by" on December 13, 2022. ULP-H stated she thought it was because "my fingerprints did not come back yet, but I had already worked by myself".</p> <p>A review of Department of Human Services Background Study website (https://netstudy2.dhs.state.mn.us/Live/PersonSearch) on January 19, 2023, at 4:39 p.m. revealed that the licensee (HFID #37197) received</p>	0 250		

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0 250	<p>Continued From page 4</p> <p>notification on November 13, 2022, to remove ULP-H due to failure to submit fingerprints and a photo. The website further indicated the licensee (HFID #37197) submitted a background study request on December 2, 2022, and as clearance had not been received. The website indicated ULP-H required supervision. The website indicated the licensee also submitted background study for ULP-H for two other of their facilities (HFID #37604 and #35310) which did not receive clearance, thus required the licensee to provide supervision of ULP-H at those facilities as well.</p> <p>A document titled "December: 46th House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. revealed ULP-H worked the following days independently: December 1 (7-4 AM), 2, (7-3 AM), 6 (7-4 AM), 7 (7-4 AM), 15 (12-4 AM), 16 (7-4 AM), 19 (3-11 PM), 20 (3-11 PM), 21 (3-11 PM), 22 (7-3 AM), 23 (3-11 PM), 25 (7-3 AM), 26 (3-11 PM), 27 (3-11 PM), 28 (3-11 PM), 29 (3-11 PM), and 30 (3-11 PM), 2022.</p> <p>A document titled "January 2023: 46 House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. revealed ULP-H worked independently on January 3 (3PM - 11 PM), 2023.</p> <p>On January 17, 2023, the MDH investigator verbally requested multiple documents from ALD-A but did not receive accurate contact information for all staff.</p> <p>On January 17, 2023, at 11:23 a.m. an e-mail received from ALD-A provided the full name and contact phone number for the following individuals as staff for the facility: ALD-A, PM-F, CO-I, RN-C, ULP-J, ULP-K, and ULP-L.</p>	0 250		

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0 250	<p>Continued From page 5</p> <p>Phone call attempts made by the investigator on January 18, 2023, found that the phone contact information provided by ALD-A for ULP-J and ULP-K were not accurate, thus the investigator was not able to interview ULP-J (who was present at the time of discovery that R2 was unresponsive).</p> <p>A document titled "January 2023: 46 House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. revealed eight additional staff (as well as ULP-H) with scheduled shifts whose full name and contact information was not provided by ALD-A.</p> <p>A document titled "December: 46th House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. revealed an individual named "Richard" (no last names on the schedule) worked "7-11 PM" on December 12, 2022. (During the time that R1's incident occurred). The schedule also indicated "Richard" worked on December 2, 2022, 11-8 NOC; December 4, 2022, 7-7 NOC; December 5, 2022, 11-7 NOC; December 10, 2022, 3-7 PM; and December 11, 2022, 3-7 PM.</p> <p>During an interview on January 17, 2023, at 9:00 a.m. PM-F stated the facility had no staff named Richard. PM-F stated she made the schedule and maybe just made a mistake.</p> <p>An e-mail received on January 18, 2023, at 6:24 p.m. from ALD-A indicated ALD-A "confirmed with [PM-F] and [CO-I] that we do not have a Richard that works for us" and indicated that CO-I worked on December 12, 2022.</p>	0 250		

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0 250	<p>Continued From page 6</p> <p>During an interview on January 19, 2023, at 3:25 p.m. unlicensed personnel (ULP)-H stated the facility employed a staff named "Richard" who primarily worked at one of the other (unnamed) houses owned by the licensee.</p> <p>Failure to provide requested video</p> <p>On January 17, 2023, at 6:00 a.m. the investigator toured the facility noting eight surveillance cameras in common areas of the building. The investigator observed a large monitor on the lower level of the building that included visuals of the eight surveillance cameras.</p> <p>During an interview on January 17, 2023, at 8:06 a.m. ALD-A stated he did not know how to retrieve the surveillance video from the cameras, as he was not "techy" and I should talk with the co-owner (CO-I) who would be able to retrieve the video for the December 12, and 13, 2022 incidents.</p> <p>During an interview on January 23, 2023, at 9:04 a.m. CO-I stated after the December 12 and 13, 2022, incidents "we tried to look at the cameras" but he was "not too tech savvy" so did not retrieve any video.</p> <p>Failure to provide requested documents</p> <p>During an interview on January 17, 2023, at 8:06 a.m. ALD-A stated on December 12, 2022, PM-F notified him of R1's unresponsive incident and he met with PM-F and RN-C to discuss R1's incident and make a plan. ALD-A also stated that on December 13, 2022, after R2's death, he met again with PM-F, RN-C, and CO-I also</p>	0 250		

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0 250	<p>Continued From page 7</p> <p>participated. ALD-A stated there was written documentation of the meetings and documentation of R1's safety checks.</p> <p>During an interview on January 18, 2023, at 12:55 p.m. RN-C stated no one called her about R1's unresponsive incident on December 12, 2022, and she did not come to the facility to meet with ALD-A and PM-F on December 12, 2022.</p> <p>During an interview on January 19, 2023, at 9:00 a.m. PM-F stated no one called RN-C to the facility after the December 12, 2022, R1 incident and RN-C did not participate in the meeting on December 12, 2022.</p> <p>On January 17, 2023, the MDH investigator verbally requested multiple items from ALD-A but did not receive the following: surveillance video; the communication notes from unlicensed staff; policy for supervision of residents; the incident report or documentation of internal investigation of the December 12, 2022, incident; the internal investigation of the December 13, 2022, incident; documentation of resident hospitalizations; grievances; or R1's hourly/two-hour safety check log.</p> <p>On January 19, 2023, the MDH investigator emailed ALD-A requesting the above documents and also documentation of RN-C, PM-F, ULP-J, and CO-I orientation to R1 and R2.</p> <p>On January 23, 2023, at 12:05 a.m. ALD-A sent an e-mail to the investigator indicating "the camera is set up to auto delete after 25 or so days. We couldn't find video footages [sic] for the above dates."</p>	0 250		

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0 250	<p>Continued From page 8</p> <p>Violation of city ordinance</p> <p>During an interview on January 18, 2023, at 2:00 p.m., an interested person (IP-E), who lived in the facility neighborhood stated the licensee illegally rented the building. IP- E stated he spoke to the city manager, who confirmed that the licensee was aware of the violation but ignored notices of city code violation.</p> <p>An e-mail received from the city manager (CM), indicated the licensee did not have a valid rental license. The e-mail indicated the city attempted to contact the licensee regarding property maintenance compliance orders and follow-up inspections, but the licensee canceled a scheduled inspection.</p> <p>The City of Robbinsdale Citations for City Code Violation document indicated the licensee was in violation of Robbinsdale City Code #425.31 Subd. 12, for transferring a rental license [subleasing]. The violations were sent on the following dates: August 1, 2022; August 31, 2022; October 4, 2022; November 3, 2022; December 6, 2022; and January 10, 2023, with the citation amount of \$2,000.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 250		
0 330 SS=I	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time	0 330		

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0 330	<p>Continued From page 9</p> <p>provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide accurate and truthful information during an investigation of two residents (R1, R2) reviewed for maltreatment. This had the potential to affect all residents and staff at the facility.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>Failure to provide accurate staff information During an interview on January 17, 2023, at 8:06 a.m., assisted living director (ALD)-A stated a new staff came down to do paperwork, and discovered a resident (R2) was unresponsive.</p> <p>During an interview on January 19, 2023, at 9:00 a.m. program manager (PM)-F stated unlicensed personnel (ULP-H) was not working on December 13, 2022, morning shift, but had come for paperwork.</p> <p>During an interview on January 19, 2023, at 3:25</p>	0 330		

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0 330	<p>Continued From page 10</p> <p>p.m. ULP-H stated she reported to the facility for work on December 13, 2022, at 7:00 a.m. ULP-H stated she entered the unlit facility and found the night staff, (ULP)-J, covered up with a blanket asleep on the couch on the main floor. ULP-H stated after the incident with R2's death, she received a call from PM-F who told her "if any one asks, just tell them that you were not at work, you just stopped by" on December 13, 2022. ULP-H stated she thought it was because "my fingerprints did not come back yet, [for the background study] but I had already worked by myself".</p> <p>A review of Department of Human Services Background Study website (https://netstudy2.dhs.state.mn.us/Live/PersonSearch) on January 19, 2023, at 4:39 p.m. indicated the licensee (HFID #37197) received notification on November 13, 2022, to removed ULP-H due to failure to submit fingerprints and a photo. The website further indicated the licensee (HFID #37197) submitted a background study request on December 2, 2022, and as clearance had not been received, ULP-H required supervision. The website indicated the licensee also submitted background study for ULP-H for two other of their facilities (HFID #37604 and #35310) which did not receive clearance, thus required the licensee to provide supervision of ULP-H at those facilities as well.</p> <p>A document titled "December: 46th House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. indicated ULP-H worked the following days independently: December 1 (7-4 AM), 2, (7-3 AM), 6 (7-4 AM), 7 (7-4 AM), 15 (12-4 AM), 16 (7-4 AM), 19 (3-11 PM), 20 (3-11 PM), 21 (3-11 PM), 22 (7-3 AM), 23 (3-11 PM), 25 (7-3</p>	0 330		

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0 330	<p>Continued From page 11</p> <p>AM), 26 (3-11 PM), 27 (3-11 PM), 28 (3-11 PM), 29 (3-11 PM), and 30 (3-11 PM), 2022.</p> <p>A document titled "January 2023: 46 House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. indicated ULP-H worked independently on January 3 (3PM - 11 PM), 2023.</p> <p>On January 17, 2023, the MDH investigator verbally requested multiple documents from ALD-A but did not receive accurate contact information for all staff.</p> <p>On January 17, 2023, at 11:23 a.m. an e-mail received from ALD-A provided the full name and contact phone number for the following individuals as all staff for the facility: ALD-A, PM-F, CO-I, RN-C, ULP-J, ULP-K, and ULP-L.</p> <p>Phone call attempts made by the investigator on January 18, 2023, found that the phone contact information provided by ALD-A for ULP-J and ULP-K were not accurate, thus the investigator was not able to interview ULP-J (who was present at the time of discovery that R2 was unresponsive).</p> <p>A document titled "January 2023: 46 House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. revealed eight additional staff (as well as ULP-H) with scheduled shifts whose full name and contact information was not provided by ALD-A.</p> <p>A document titled "December: 46th House Schedule" retrieved at the facility from a bulletin board by the investigator on January 17, 2023, at 6:15 a.m. indicated an individual named "Richard"</p>	0 330		

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0 330	<p>Continued From page 12</p> <p>(no last names on the schedule) worked "7-11 PM" on December 12, 2022. (During the time that R1's incident occurred). The schedule also indicated "Richard" worked on December 2, 2022, 11-8 NOC; December 4, 2022, 7-7NOC; December 5, 2022, 11-7 NOC; December 10, 2022, 307 PM; and December 11, 2022, 3-7 PM.</p> <p>During an interview on January 17, 2023, at 9:00 a.m. PM-F stated the facility had no staff named Richard. PM-F stated she made the schedule and maybe just made a mistake.</p> <p>An e-mail received on January 18, 2023, at 6:24 p.m. from ALD-A indicated ALD-A "confirmed with [PM-F] and [CO-I] that we do not have a Richard that works for us" and indicated that CO-I worked on December 12, 2022.</p> <p>During an interview on January 19, 2023, at 3:25 p.m. unlicensed personnel (ULP)-H stated the facility employed a staff named "Richard" who primarily worked at one of the other (unnamed) houses owned by the licensee.</p> <p>Failure to provide requested video On January 17, 2023, at 6:00 a.m. the investigator toured the facility noting eight surveillance cameras in common areas of the building. The investigator observed a large monitor on the lower level of the building that included visuals of the eight surveillance cameras.</p> <p>During an interview on January 17, 2023, at 8:06 a.m. ALD-A stated he did not know how to retrieve the surveillance video from the cameras, as he was not "techy" and I should talk with the co-owner (CO-I) who would be able to retrieve the</p>	0 330		

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0 330	<p>Continued From page 13</p> <p>video for the December 12, and 13, 2022 incidents.</p> <p>During an interview on January 23, 2023, at 9:04 a.m. CO-I stated after the December 12 and 13, 2022, incidents "we tried to look at the cameras" but he was "not too tech savvy" so did not retrieve any video.</p> <p>Failure to provide requested documents</p> <p>During an interview on January 17, 2023, at 8:06 a.m. ALD-A stated on December 12, 2022, PM-F notified him of R1's unresponsive incident and he met with PM-F and RN-C to discuss R1's incident and make a plan. ALD-A also stated that on December 13, 2022, after R2's death, he met again with PM-F, RN-C, and CO-I also participated. ALD-A stated there was written documentation of the meetings and documentation of R1's safety checks.</p> <p>During an interview on January 18, 2023, at 12:55 p.m. RN-C stated no one called her about R1's unresponsive incident on December 12, 2022, and she did not come to the facility to meet with ALD-A and PM-F on December 12, 2022.</p> <p>During an interview on January 19, 2023, at 9:00 a.m. PM-F stated no one called RN-C to the facility after the December 12, 2022, R1 incident and RN-C did not participate in the meeting on December 12, 2022.</p> <p>On January 17, 2023, the MDH investigator verbally requested multiple items from ALD-A but did not receive the following: surveillance video, the communication notes from unlicensed staff, policy for supervision of residents, the incident report and documentation of internal investigation of December 12, 2022, incident, internal</p>	0 330		

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0 330	<p>Continued From page 14</p> <p>investigation of December 13, 2022, incident, documentation of resident hospitalizations, grievances, or R1's hourly/two-hour safety check log.</p> <p>On January 19, 2023, the MDH investigator emailed ALD-A requesting the above documents and also orientation/training records for RN-C, PM-F, ULP-J, and CO-I, documentation of RN-C, PM-F, ULP-J, and CO-I orientation to R1 and R2.</p> <p>On January 23, 2023, at 4:30 p.m. the licensee had not provided the requested documentation or video.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) Days</p>	0 330		
0 630 SS=J	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to update an individual abuse prevention plan (IAPP) with specific interventions</p>	0 630	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software.	

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0 630	<p>Continued From page 15</p> <p>to address the potential for self-harm from one of one residents (R1) reviewed for maltreatment when R1 overdosed on illicit drugs while in the facility, required Narcan for revival, and went to the hospital.</p> <p>The facility was notified of the immediacy on January 20, 2023.</p> <p>The immediacy was removed on January 30, 2023. However non-compliance remains at a scope and level of J.</p> <p>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).</p> <p>Findings include:</p> <p>R1 admitted to the assisted living facility on June 20, 2022, due to diagnoses that included bipolar disorder and substance use disorder. R1's service plan dated September 6, 2022, indicated R1 received services that included medication administration, meals, laundry, housekeeping, daily "I'm OK checks", and "daily management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, and self-injury".</p> <p>R1's progress note dated December 13, 2022, written by registered nurse (RN)-C indicated R1 was found unresponsive and taken to the hospital during the previous night (December 12, 2022). The progress note further indicated that R2 (in who's room R1 collapsed) told staff R1 had</p>	0 630	<p>Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	

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0 630	<p>Continued From page 16</p> <p>smoked marijuana and meth.</p> <p>R1's individual abuse prevention plan dated December 13, 2022, written by RN-C, indicated "false" under alcohol, chemical and/or other medication abuse. The IAPP had no interventions identified for staff to implement in the event of R1's suspected alcohol, chemical, or medications abuse.</p> <p>During an interview on January 17, 2023, at 8:06 a.m., assisted living director (ALD)-A stated he, RN-C, and program manager (PM)-F met at the facility on December 12, 2022, after they were notified of R1's episode of unresponsiveness. ALD-A stated there was evidence of drug use in the incident because the incident happened in R2's room and R2 had a history of drug abuse. ALD-A stated he was aware that R1 required Narcan (an emergency rescue medication used to reverse an overdose of opioid's). ALD-A stated the facility implemented two-hour safety checks but provided no evidence of the discussion or of the safety checks.</p> <p>During an interview on January 18, 2023, at 12:55 p.m., RN-C stated staff did not notify her of R1's episode of unresponsiveness until the next day. RN-C stated she did not participate in a meeting after R1's incident but heard the next day R1 went to the hospital while she was at the facility due to R2's death. RN-C stated she did not know R1 required Narcan for revival. RN-C stated use of Narcan would lead her to believe R1 had a drug overdose. RN-C stated if she had been told about R1's drug overdose, she would have called the provider for an order for narcan, had staff closely monitor both R1 and R2, and send R2 to the hospital for an evaluation. RN-C stated the actions could have prevented R2's death, who</p>	0 630		

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0 630	<p>Continued From page 17</p> <p>overdosed at the facility later in the morning.</p> <p>The Assessments, Reviews, and Monitoring policy (undated) indicated the resident would receive a nursing assessment and monitoring as needed based on changes in the needs of the resident.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) Days</p>		0 630		
02310 SS=J	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide interventions and follow up with a nurse to address or minimize illicit drug use for two of two residents (R1 and R2) reviewed for maltreatment. R1 overdosed in R2's room and paramedics revived him with Narcan (an emergency rescue medication used to reverse an overdose of opioid's). Facility staff did not notify the nurse of R1's overdose while in R2's room and no interventions were put in place for either R1 (who returned to the facility) or R2, who had a history of drug abuse. The next morning R2 was found in the facility deceased of a drug overdose. Staff allegedly had last seen R2 seven hours earlier.</p> <p>This practice resulted in a level four violation (a</p>		02310		

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02310	<p>Continued From page 18</p> <p>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).</p> <p>Findings included:</p> <p>R1 admitted to the assisted living facility on June 20, 2022, due to diagnoses including bipolar disorder and substance use disorder. R1's service plan dated September 6, 2022, indicated R1 received services that included medication administration, meals, laundry, housekeeping, daily "I'm OK checks", and "daily management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, and self-injury".</p> <p>R1's six-month treatment report extension request dated April 11, 2022, recommended R1's commitment continue for an additional six months due to R1's history of substance use which increased symptoms of paranoia, suicidal thoughts, delusions, and hallucinations. R1's order for continued commitment as mentally ill dated May 4, 2022, indicated the court continued R1's commitment through November 3, 2022.</p> <p>R1's progress note dated December 13, 2022, written by registered nurse (RN)-C indicated R1 was found unresponsive and taken to the hospital during the previous night (December 12, 2022). The progress note further indicated that R2 (in who's room R1 collapsed) told staff R1 had smoked marijuana and meth (methamphetamine).</p> <p>R1's individual abuse prevention plan (IAPP) dated December 13, 2022, written by RN-C,</p>	02310		

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02310	<p>Continued From page 19</p> <p>indicated "false" (indicating not a vulnerability) under the category of alcohol, chemical and/or other medication abuse. The IAPP had no interventions identified for staff to implement in the event of R1's suspected alcohol, chemical, or medication abuse.</p> <p>R2 admitted to the facility on July 1, 2022, due to diagnoses that included history of substance abuse, anxiety, depression, and schizoaffective disorder. R2's record contained an undated/untitled document that indicated R2 had a history of drug abuse and staff were to monitor for symptoms of drug use/abuse. The document directed staff to "redirect her to a safe place or reposition her." The document directed staff to call 911 if R2 was unresponsive or if respirations were less than 12.</p> <p>R2's IAPP dated December 1, 2022, written by RN-C, indicated "true" (indicating a vulnerability) under the category of alcohol, chemical and or other medication abuse. The IAPP did not include staff interventions.</p> <p>A law enforcement report dated December 12, 2022, at 20:13 (8:13 p.m.) indicated officers responded to the facility for a report of a person down. The officers found R1 unresponsive on the floor in R2's room with a person (believed to be R2) performing chest compressions. An officer checked R1 and found a pulse. The officer then administered Narcan, after which R1 regained consciousness. Paramedics arrived and transported R1 to the hospital.</p> <p>A law enforcement report dated December 13, 2022, at 7:38 a.m. indicated officers responded to the facility for a report of an unconscious person. The report indicated staff directed officers to the</p>	02310		

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02310	<p>Continued From page 20</p> <p>lower level and found R2 unresponsive in a common area on a couch leaning towards the right with her face on a cushion. An officer tried to locate a pulse but did not. The officer indicated R2 was warm to the touch, so they moved R2 to the floor and began CPR. The report indicated paramedics arrived and took over life saving measures but were unsuccessful. Paramedics determined R2 deceased at 8:00 a.m. The report indicated the crime lab arrived to take crime scene photos, and the medical examiner arrived to take R2 to the medical examiner's office. The report indicated (unknown) staff advised the officers that the staff were going to search R2's bedroom for narcotics. The report indicated co-owner (CO)-H brought out to the squad car a glass bubble pipe (identified by an officer based on training and experience as known for smoking methamphetamine) and a rolled-up dollar bill, which officers took to the police department. The report recommended linking the two cases (R1 on December 12, 2022, and R2 on December 13, 2022) and follow them up together.</p> <p>During an interview on January 17, 2023, at 8:06 a.m., assisted living director (ALD)-A stated the program manager (PM)-F called ALD-A on December 12, 2022, to inform him R1 went to the hospital after an unresponsive episode that occurred in R2's room. ALD-A stated he met with PM-F and registered nurse (RN)-C at the facility the evening of December 12, 2022. ALD-A stated they discussed the incident and due to R2's history of illicit drug use, they searched R2's room for drugs or paraphernalia. ALD-A stated he believed the paramedics used Narcan to revive R1 who likely used illicit drugs. ALD-A stated they implemented safety checks every two hours. ALD-A could not provide documentation of the meeting noted above or of safety checks</p>	02310		

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02310	<p>Continued From page 21</p> <p>implemented. ALD-A stated he got another call from PM-F the next morning (December 13, 2022), to inform him that R2 also had an unresponsive episode. ALD-A stated when he got to the facility R2 was deceased. ALD-A stated they had another meeting (with RN-C, PM-F, and co-owner (CO)-I) to talk about what happened. ALD-A stated they interviewed the staff working overnight and searched R2's room, looking for "drug related" items. ALD-A stated the facility required all residents to sign a behavior contract (which included information that the facility had zero tolerance for alcohol or drug use and that anyone violating the policy would be asked to leave) but did not enforce the behavior contract.</p> <p>During an interview on January 18, 2023, at 12:55 p.m. RN-C stated she heard about R2's overdose from PM-F, who called her in the early morning of December 13, 2022. RN-C stated she responded to the facility and saw paramedics, police, and staff from the coroner's office. RN-C stated she was concerned about how long R2 had been deceased and when the last time a staff observed her. RN-C stated she learned at that time that R1 had an unresponsive episode around 8:00 p.m. the night before while in R2's room. RN-C stated staff did not call her and she did not attend a meeting after R1's incident. RN-C stated she did not know until the time of the interview that police revived R1 with Narcan. RN-C stated the facility knew that R2 had a history of illicit drug use, and someone should have informed RN-C of R1's unresponsive episode and need for Narcan earlier in the evening, especially since it occurred in R2's room. RN-C stated that if staff had called her regarding R1, R2 would be alive. RN-C stated if she knew about R1's incident, she would have directed staff to search R2's room, watch both R1 and R2 closely, and send R2 to the hospital for an</p>	02310		

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02310	<p>Continued From page 22</p> <p>evaluation. RN-C stated the staff were not medically trained and should have called the nurse.</p> <p>During an interview on January 19, 2023, at 9:00 a.m. program manager (PM)-F stated she received a call on December 12, 2022, from co-owner (CO)-I, who indicated R1 had collapsed in R2's room. PM-F stated by the time she arrived at the facility R1 was gone to the hospital. PM-F stated she looked in R1's room for drugs or paraphernalia. PM-F stated they did not call the nurse but did discuss having staff conduct hourly room checks on R1 when he returned from the hospital. PM-F stated they created a document to track room checks (the alleged document was not provided to the investigator).</p> <p>During an interview on January 19, 2022, at 10:55 a.m. R1's mental health case manager (CM)-G stated R1 had a history of illicit drug use, and the facility did not notify her of R1's incident on December 12, 2022. CM-G stated a hospital social worker informed CM-G of R1's hospitalization but received no details. CM-G stated she asked R1 about the incident several days later and R1 reported he had a seizure. CM-G stated if the facility had notified her, she would have provided R1 with additional support for substance use.</p> <p>During an interview on January 19, 2023, at 3:25 p.m. unlicensed personnel (ULP)-H stated she reported to the facility for work on December 13, 2022, at 7:00 a.m. ULP-H stated she entered the unlit facility and found the night staff (ULP)-J asleep on the couch on the main floor, covered up in a blanket. ULP-H stated she turned on the lights, told ULP-J to get up and made coffee. ULP-H stated she then went down to the lower level and</p>	02310		

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02310	<p>Continued From page 23</p> <p>saw someone on the couch. ULP-H stated she identified the person as R2 and attempted to wake R2 by calling her name and then shook R2's shoulder. ULP-H stated R2's arm was cold and R2 did not move so she ran upstairs. ULP-H stated she again yelled to ULP-J and told him to get up and help her, something was wrong with R2. ULP-H stated she called CO-I and ULP-J called PM-F and then one of them called 911. ULP-H stated lots of people showed up, like police and paramedics, and they declared R2 deceased.</p> <p>The Assessments, Reviews, and Monitoring policy (undated) indicated the resident would receive a nursing assessment and monitoring as needed based on changes in the needs of the resident.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days.</p>	02310		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure 1 of 1 residents reviewed (R1) was free from maltreatment.</p> <p>Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the</p>	02360	<p>No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.</p>	

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02360	Continued From page 24 maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		