Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL401909206M
Compliance #: HL401906885C

Date Concluded: July 8, 2024

Name, Address, and County of Licensee Investigated:
Loon Home Health Care LLC
8651 Queen Avenue South
Bloomington, MN 55431
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
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 a resident when the facility failed to supervise a resident which resulted in multiple elopements.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision necessary to ensure resident safety. The resident eloped multiple times, spending multiple nights on the streets, and was arrested during an elopement in a vehicle not belonging to her.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the residents case manager. The investigation included review of medical records, police reports, personnel files, and facility policies. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, anxiety, substance use disorder, and depression. The resident's service plan included assistance with dressing, grooming, assistance while in community, medication management, and a daily safety check.

The resident's admission assessment indicated she had short term memory loss and history of drug and alcohol use. The elopement section was partially completed. The resident's individual abuse prevention plan (IAPP) indicated she was at risk for wandering/elopement and staff would monitor her whereabouts.

Nine days after admission, the resident's progress note indicated she was dropped off at a store to shop independently and the resident did not return to the facility. The resident's record lacked indication staff attempted to locate the resident or report her missing to authorities, her case manager or medical provider. Four days, while still missing, staff documented the resident had a warrant issued for her arrest and she was required to report to jail. The next day, the progress note indicated the resident did not report to jail.

The resident's 14-day assessment completed "in person", indicated there were no changes to the resident's status and no changes need for her care plan or services. The assessment failed to include the resident's elopement information being missing for five days (at the time of the assessment). The assessment indicated there were no changes to the resident's safety and vulnerability.

The next day, the resident's progress note indicated she returned to the facility.

Three days after returning from being missing from the facility for six days, the resident's progress note indicated she eloped from the facility the day prior and returned at 1:00 a.m. The resident was extremely aggressive and refused to take her medication.

The resident's record lacked an registered nurse (RN) change in condition assessment for the resident's second elopement and change in behaviors.

The next day, the resident's progress note indicated she had been loud, pounding on other resident's doors and then left the facility.

A law enforcement report on the same date indicated officers responded to the facility on a missing person report. Owner 2 reported to law enforcement the resident was a "vulnerable adult" but could come and go from the facility as she pleased, and this was somewhat normal for her. Owner 2 stated the facility policy was to report a missing person after they have been gone for 24 hours. The report indicated, in the past staff have attempted to locate the resident, but this elopement they have not attempted to locate the resident.

Four days into being missing from the resident's third elopement, the resident's progress note indicated she was observed on the side of the road by a tent. There were no further progress notes indicating any interventions to return the resident to the facility, or attempts to provide safety, or alerting 911 for finding the missing resident to return the resident to the facility or turn her over to law enforcement for her arrest warrant.

After being missing for 23 days, the resident's progress note indicated she returned to the facility and refused to talk to the nurse. There were no further progress notes following up with the resident regarding her being missing for 23 days or on her condition.

The resident's record lacked a RN change in condition assessment after the resident's third elopement. There was no record on assessing the resident's safety or assessment for any injuries or medical changes while being away from the facility. As a result, the resident's IAPP remained unchanged with no interventions for her elopement risk and no new services were implemented. The resident continued a daily safety check frequency.

The resident's record lacked any documentation or progress notes on her status for approximately five weeks. A progress note indicated the resident was arrested for driving under the influence. Two days later, a progress note only dictated "out of jail."

The resident's record lacked an RN assessment after the resident's fourth elopement. There was no record assessing the resident's safety or assessment for any injuries or medical changes while being away from the facility in jail. There was no record indicating when the resident left the facility, how it came to be that she was driving, who's vehicle it belonged to, interventions staff attempted to prevent the elopement, alerting 911 when she eloped or communications with her medical provider or case manager.

A law enforcement report dated five days prior to the facility's progress note regarding the resident being arrested indicated law enforcement observed a suspicious vehicle parked at a boat launch belonging to someone else, not the resident. The reported indicated the officer observed the resident in the vehicle "frantically rocking back and forth" and looking around. There were two individuals in the vehicle, the resident was the driver. The resident told the officer she came to the water to wash her feet, although the lake was frozen. After obtaining the resident's identity, the report indicated she had a felony warrant issued five days after her facility admission for drugs. Drug paraphernalia was located in the vehicle as well as large amounts of currency in the resident's purse.

The resident's record lacked an updated IAPP since admission and no interventions for elopement risk. The resident's service plan remained unchanged from admission with no new services and continued a daily frequency of a safety check.

Approximately two months later, the resident's quarterly care plan and IAPP update failed to indicate the resident was an elopement risk, nor address any safety interventions.

During an interview, the resident said the voices told her she needed to help homeless people in Minneapolis. She said she took medication but was unable to state which ones she currently took, and several medications made her sick. She said her mission is “Operation Social Change.” She said she continued to elope from the facility because other people need her help. She said she was recently arrested and has been arrested several times because the police dislike her.

During an interview, owner 1 said the resident left the facility and failed to return on many occasions. During one episode the resident was gone for almost a month. The resident stayed on the streets in Minneapolis and was arrested. Owner 1 said resident had a right to come and go as she chose despite risky, and unsafe behaviors. The facility had not implemented interventions to prevent further incidents.

During an interview, owner 2 said during the first elopement owner 1 and himself, dropped the resident off in downtown Minneapolis to go shopping and she never returned. He said she was supposed to call them for a ride home, but she never called. They found her the next day on the street in Minneapolis and she told them, “Give me personal space.” The resident returned to the facility and left again several times in the next couple weeks. She eventually left and did not return to the facility for almost one month. He said no incident reports were completed. He was unsure if resident’s assessments were updated.

During an interview, the nurse said the resident was never assessed as an elopement risk despite several elopements. The nurse said interventions were not implemented to prevent the resident from leaving and not returning. The resident did not take medications currently. The nurse said the resident has left and not returned to the facility many times. The nurse said the resident left the other day and failed to return.

During an interview, the case manager said resident has eloped several times since admission. The resident has also been arrested several times. She said the resident was arrested for drug possession, driving while under the influence, and tampering with a motor vehicle. The facility keeps her updated about resident elopements but has not discussed interventions to keep her safe or prevent future incidences. The resident was in jail at the time of the interview as she was recently arrested .The resident did not take her prescribed medications.

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

Action taken by facility:
The facility has looked for the resident when she has eloped and reported a missing person to law enforcement.

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
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOON HOME HEALTH CARE LLC	8651 QUEEN AVENUE SOUTH BLOOMINGTON, MN 55431

(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: #HL401906885C /#HL401909206M On May 1, 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 five (5) residents receiving services under the provider's provisional Assisted Living license. The following correction orders are issued for #HL401906885C /#HL401909206M, tag identification 1620, 2360.	0 000	Minnesota Department of Health is documenting the State 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 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess a resident after multiple elopements and criminal behavior for one of one resident (R1) reviewed. As a result, elopement interventions were not implemented and R1 had elopements for multiple days before returning to the licensee. 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	01620		

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01620	Continued From page 2 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). The findings include: R1 admitted October 18, 2023. R1's diagnoses included schizoaffective disorder, depression, anxiety, traumatic brain injury, and chronic pain. R1's service plan dated October 18, 2023, indicated R1 received services for medication management, daily safety checks, activities in the community, dressing, laundry, and housekeeping. R1's Uniform Assessment Tool dated October 18, 2023, completed by registered nurse (RN)-C, indicated R1 had short term memory loss and a history of drug and alcohol use. An elopement assessment was included in the Uniform Assessment Tool. R1's elopement assessment was partially completed as not all questions were answered. The assessment indicated R1 had no diagnoses or substance use that would increase R1's risk of elopement. R1's Individual Abuse Prevention Plan (IAPP) dated October 18, 2023, indicated R1 was at risk for wandering/elopement and staff would monitor R1's whereabouts. R1's unauthenticated progress notes dated October 27, 2023, indicated R1 was dropped off in Minneapolis to shop and never returned to the facility. R1's unauthenticated progress notes dated October 31, 2023, indicated R1 had a warrant for her arrest and must report to jail.	01620		

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01620	Continued From page 3 R1's unauthenticated progress notes dated November 1, 2023, indicated R1 never reported to jail. R1's unauthenticated progress notes dated November 2, 2023, indicated R1 returned to the facility. R1's 14 day assessment dated November 1, 2023, completed in person by RN-C, although R1 had not returned to the facility until November 2, 2023, indicated there were no changes to R1's status and no changes needed for R1's care plan and services. The assessment failed to included R1's elopement from the facility from October 27, 2023 until November 2, 2023 (6 days). The assessment indicated there were no changes for R1's safety and vulnerability. R1's unauthenticated progress notes dated November 5, 2023, indicated R1 eloped from the facility again November 4, 2023. Upon return November 5, 2023, at 1:00 a.m., R1 was extremely aggressive and refused to take her medication. R1's record lacked an RN assessment after R1's second elopement and change in behaviors November 4 and 5, 2023. R1's unauthenticated progress notes dated November 6, 2023, indicated R1 had been loud, pounding on resident's doors and then left the facility. A law enforcement report dated November 6, 2023, indicated officers responded to the licensee on a missing person report. Owner (OW)-B reported R1 left the facility on November 5, 2023, at 10:30 p.m. OW-B reported to law enforcement	01620		

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01620	Continued From page 4 R1 was a "vulnerable adult" but could come and go from the facility as she pleased and this was somewhat normal for her. OW-B stated the facility policy is to report a missing person after they have been gone for 24 hours. The report indicated, in the past staff have attempted to locate R1, but this elopment they have not attempted to locate R1. R1's unauthenticated progress notes dated November 10, 2023, indicated R1 was observed on the side of the road in Minneapolis by a tent. There were no further progress notes indicating any interventions to return R1 to the facility, or attempts to provide safety, or alerting 911 for finding R1 to return R1 to the facility or turn her over to law enforcement for her arrest warrant. R1's unauthenticated progress notes dated November 29, 2023, indicated R1 returned to the facility and refused to talk to the nurse. There were no further progress notes following up with R1 regarding being missing for 23 days or on her condition. R1's record lacked an RN assessment after R1's third elopement on November 6, 2023, resulting in being missing from the facility for 23 days. There was no record on assessing R1's safety or assessment for any injuries or medical changes while being away from the facility. R1's record indicated R1's IAPP was not updated since admission on October 18, 2023, and no interventions for elopement risk. R1's service plan remained unchanged from October 18, 2023, with no new services and continued a daily frequency of a safety check.	01620		

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01620	Continued From page 5 No further progress notes written until January 7, 2024. R1's unauthenticated progress notes dated January 7, 2024, indicated R1 was arrested for driving under the influence. R1's unauthenticated progress notes dated January 9, 2024, wrote "out of jail." R1's record lacked an RN assessment after R1's fourth elopement on January 7, 2024. There was no record on R1's safety or assessment for any injuries or medical changes while being away from the facility in jail. There was no record indicating when R1 left the facility, how she was driving, who's vehicle it belonged to, interventions staff attempted to prevent the elopement, alerting 911 when she eloped or communications with her providers or case manager. A law enforcement report dated January 2, 2024, indicated law enforcement observed a suspicious vehicle parked at a boat launch belonging to someone (not R1) in Sparta, Wisconsin. The reported indicated R1 was observed in the vehicle "frantically rocking back and forth" and looking around. There were two individuals in the vehicle, R1 was the driver. R1 told the officer she came to the water to wash her feet, although the lake was frozen. After obtaining R1's identity, she had a felony warrant issued on October 23, 2023 [after R1's admission] for drugs. Drug paraphernalia was located in the vehicle as well as large amounts of currency in R1's purse. R1's record indicated R1's IAPP was not updated since admission on October 18, 2023, and no interventions for elopement risk.	01620		

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01620	Continued From page 6 R1's service plan remained unchanged from October 18, 2023, with no new services and continued a daily frequency of a safety check. R1's Master Care Plan dated March 28, 2024, inaccurately indicated R1 was not at risk for elopement and no interventions were added. R1's IAPP dated March 28, 2024, inaccurately indicated R1 was not at risk for elopement and no interventions were indicated. On May 2, 2024, at 11:00 a.m., OW-A said R1 was never assessed as an elopement risk. OW-A said R1 left the facility multiple times and failed to return when agreed upon. R1's IAPP was never updated with interventions to prevent elopement. On May 16, 2024, at 1:10 p.m., RN-C said a different nurse completed R1's initial nursing assessment as he was unavailable. RN-C said although R1 left and did not return to the facility multiple times, he never completed a change in condition or updated R1's assessments. He said he did not consider her leaving and not returning as an elopement. He said he never spoke to R1's county case manager about her care plan. He never updated R1's assessments after R1 was arrested for driving under the influence. R1's medical record failed to identify R1 as an elopement risk and failed to identify interventions to prevent further incidents. The Nurse Practice Act, Minnesota Statute Section 148.171, indicates a RN scope of practice includes: (1) providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish	01620		

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01620	Continued From page 7 a health status baseline and plan of care, and address changes in a patient's condition; (3) developing nursing interventions to be integrated with the plan of care; (10) evaluating responses to interventions and the effectiveness of the plan of care; The licensee's Assessment and Reassessment dated March 18, 2024, indicated ongoing assessments must be conducted based on changes in resident needs. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
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. 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, 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.	