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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL362369262M
**Compliance #:** HL362363169C

**Date Concluded:** May 11, 2026

**Name, Address, and County of Licensee Investigated:**
Midtown Housing Services
2830 12th Avenue South
Minneapolis, MN 55407
Hennepin County

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

**Evaluator's Name:** Brandon Martfeld, 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 the facility failed to provide supervision for a resident that overdosed on illicit drugs and died.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess, develop, and implement a person-centered plan of care when the resident showed a pattern of illicit drug use and behaviors. As a result, the resident's interventions were not reassessed for effectiveness or appropriateness and lacked any new interventions to reduce the resident's risk of endangering herself.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a physician and law enforcement.

The investigation included a review of the resident records, death record, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and other resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and bipolar disorder. The resident's service plan included assistance with behavior management and nine safety checks. The resident's assessment indicated the resident was alert and oriented. When the resident used illicit drugs, she would become physically aggressive, and staff were to notify leadership immediately. Additional interventions were to maintain a safe environment, set clear boundaries, and attempt to calm tense situations.

The resident's medical record indicated two months prior to the resident's death, the resident was found with syringes, needles, and tinfoil in her room. The medical record indicated the resident used illicit drugs and a "serious concern" for using fentanyl. The resident's medical record lacked direction to the facility staff on what to do if the resident sought and/or obtained these items.

The resident's medical record indicated 14 days prior to the resident's death there were daily incidences documented that included the resident being verbally aggressive with facility staff, agitation, a threat to kill staff, hallucination, and paranoia. The resident used illicit drugs and stated only illicit drugs helped. The resident's medical record indicated the facility leadership was aware of the resident's illicit drug use and behaviors. However, the medical record lacked reassessment and/or new interventions for facility staff to implement related to the incidents.

The medical record indicated that during an overnight shift, unlicensed staff #2 documented the resident was hearing voices and used illicit drugs. The resident's medical record lacked evidence that facility leadership was updated.

The medical record indicated the evening before the resident's death, unlicensed staff #1 documented the resident was seeking tinfoil and told facility staff it was for illicit drug use. The resident's medical record lacked evidence that facility leadership was updated.

The facility investigation indicated the evening before her death,-the resident reported to unlicensed staff #1 that she was going to sleep and did not want to be disturbed. Unlicensed staff #2 reported they heard the resident moving around between the hours of midnight and one o'clock in the morning. When the resident did not come down from her room at her usual time the next morning, unlicensed staff #2 completed a safety check and found the resident unresponsive. Unlicensed staff #2 notified emergency medical services immediately, and the resident was pronounced deceased.

The police report indicated the resident was last seen the evening before at approximately 5:30 p.m. When the resident did not come down for breakfast, an unlicensed staff member went to check on the resident. The resident was found face down on the floor with a lighter in one hand and a homemade pipe constructed from a plastic pen in the other hand. In addition, the police report indicated the resident was asking for tinfoil the evening prior and that the tinfoil was found inside the resident's room.

The resident's death certificate indicated the resident's cause of death was fentanyl and methamphetamine toxicity.

The resident's medical record lacked specific individualized interventions related to the resident's illicit drug use. The medical record failed to provide directions related to the resident's illicit drug use when facility staff should report, what to report, and who to report to.

During an interview, unlicensed staff #1 stated the evening prior to the resident being found deceased, the resident left the facility for a little bit and came back with a visitor. The resident and the unknown visitor sat on the front porch of the facility. After a while the resident came into the facility and stated she was tired and was going to sleep. Unlicensed staff #1 stated the resident requested that he tell the unknown visitor to leave the facility. The resident did not come out of her room for the rest of the evening shift. Unlicensed staff #1 stated there was a previous incident with the resident in which she was on the front porch of the facility using tinfoil and a glass pipe to smoke illicit drugs. Unlicensed staff #1 stated they were aware the resident had a history of using illicit drugs, and if the resident was suspected to be using illicit drugs or was under the influence of illicit drugs, then facility leadership would be notified.

During an interview, unlicensed staff #2 stated that during the overnight shift, the resident did not leave her room; however, she could be heard walking around in her room and using the bathroom. Unlicensed staff #2 stated he did not see the resident because the resident did not like staff knocking on her door. The following morning, the resident did not come downstairs for her appointment. Unlicensed staff #2 stated he went to the resident's room, knocked three times, and did not get an answer. When the resident did not respond, unlicensed staff #2 entered the resident's room and found her unresponsive. Unlicensed staff #2 stated emergency medical services were called immediately, and they arrived within a minute. Emergency medical services pronounced the resident deceased. Unlicensed staff #2 stated he did not suspect the resident of using illicit drugs during his shift.

During an interview, facility leadership stated if a resident was suspected to be under the influence of illicit drugs, safety checks would be increased to ensure the resident's safety. Also, the mental health crisis team would be called along with the local police for assistance. It was well known among the facility staff and the resident's medical care team that she used illicit drugs. Facility leadership stated unlicensed staff did not notify her that the resident was looking for tinfoil to use illicit drugs the evening before she was found deceased. Facility leadership stated if she had known the resident was attempting to gather tinfoil for illicit drug use, she

would have called the mental health crisis team and increased safety checks even if the resident did not want to be disturbed because using illicit drugs was a safety concern. Facility leadership stated it was well known the resident used illicit drugs.

During an interview, a family member stated the resident suffered from mental health and was paranoid. The family member stated the resident's illicit drug of choice was methamphetamine but also started taking fentanyl.

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. The resident was deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
When the resident was found unresponsive, emergency medical services were notified.

**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
Minneapolis City Attorney
Minneapolis Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36236 | A. BUILDING: _____ B. WING _____ | C 04/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDTOWN HOUSING SERVICES LLC | 2830 12TH AVENUE SOUTH MINNEAPOLIS, MN 55407 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL362369262M / #HL362363169C<br><br>On April 20, 2026, 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 2 residents receiving services under the provider's Assisted Living license.<br><br>The following correction order is issued for #HL362369262M / #HL362363169C, tag identification 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, | 02360 | | |

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| 02360 | Continued From page 1<br><br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident (R1) reviewed was free from maltreatment.<br><br>Findings include:<br><br>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 | | |