Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL365414941M
Compliance #: HL365416511C

Date Concluded: December 5, 2024

Name, Address, and County of Licensee Investigated:
Goldenview Healthcare Services
1001 65th Avenue North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
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 they failed to provide adequate supervision and care, placing the resident's safety at risk when the resident eloped from the facility and was missing for three days.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was her own decision maker and able to come and go freely from the facility. The facility monitored the resident and provided cares and medications as the resident allowed. The facility communicated noncompliance of the resident's medications with the medical provider. After a hospitalization, the resident received inpatient psychiatric care and readmitted to the facility with injection medication to improve medication compliance.

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

investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and resident interactions while on site.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and developmental disorders. The resident's service plan included assistance with medication administration, reminders to complete activities of daily living, and safety checks. The resident's assessment indicated the resident was independent with walking and had a history of agitation, refusal of cares, elopement, and physical abuse to others. The resident was her own decision maker and was able to come and go freely from the facility.

The resident's individual abuse prevention plan (IAPP) indicated the resident was at risk for abuse related to her mental health diagnosis, history of refusing care, agitation, and history of elopement.

The resident's mental health care plan directed staff to encourage the resident to voice concerns, remain calm, to not argue with the resident, explain to the resident the importance of cares to improve health, offer choices, and speak to the resident calmly and respectfully to manage the resident's behaviors. The staff were directed to perform safety checks every two hours and call 911 and the nurse in case of emergency.

The resident's medication administration record showed noncompliance with her psychiatric medications due to being away from the facility. The resident's progress note prior to the hospitalization indicated the nurse noted the resident's noncompliance with psychiatric medications due to being away from the facility so often and had planned to discuss with her medical provider and care team for intervention. Additionally, the resident's service records showed staff provided safety checks and cares she required when she was at the facility.

Law enforcement records indicated the resident required law enforcement response, at least five times while she was out in the community. During the reported incident of concern, the facility incident report indicated the resident left the facility and staff had not seen or heard from the resident for over 24 hours. The facility staff submitted a missing person's report with law enforcement.

A day after the facility filed a missing person report, the resident's hospital record indicated the resident had been located naked in a car wash bay and received transportation to the hospital. The resident's hospital record indicated the resident's medical work up was unremarkable, but the resident exhibited aggression, abnormal body movements, and non-compliance. The hospital medical provider submitted recommendation for a civil commitment and Jarvis (court order for medication compliance). The resident remained in the hospital for five days before a transfer to a mental health facility for an inpatient mental health admission and return to the facility.

The resident's readmission assessment indicated the discontinuation of an oral psychotropic medication and initiation of a monthly psychotropic medication injection to aide in medication compliance. This medication change resulted in the resident no longer having to endure routine blood draws.

A subsequent law enforcement report indicated the resident required an additional law enforcement response while out in the community, away from the facility, with hospital admission.

The resident's hospital record indicated at the time of the second hospitalization she was not on civil commitment.

Facility staff stated the resident did not return to the facility after this hospitalization. The resident admitted to another facility.

During investigative interviews, multiple staff members stated the resident was her own person who made her own decisions. The staff stated the resident left the facility on her own multiple times in a week. They stated the resident would sometimes tell them where she was going, but most of the time did not.

During an interview, the activities coordinator (ACT) stated he would try to keep the resident busy as an intervention to prevent elopements. The ACT stated he would take the resident to the store, gas station, and anywhere else the resident wanted to go. The ACT stated he would take the resident for a leisure drive and staff were available to take her anywhere she would want to go. The ACT stated staff verbally educated the resident on why it was not safe for her to elope from the facility and reinforced they could take her anywhere she wanted to go. The ACT stated when the resident would return to the facility after an elopement, she would stay at the facility for a few days, but then leave again.

During an interview, the nurse stated staff received in person and online training on how to manage behaviors and mental health concerns. The nurse stated staff alerted management if a resident had not returned to the facility as expected, and the staff would go look for the resident. The nurse stated management submitted a Minnesota Adult Abuse Reporting Center (MAARC) report if the resident was not located within 24 hours. The nurse stated she updated the resident's IAPP if there were any new changes and completed a hospital return assessment to assess for any new changes needed for the resident's plan of care. The nurse stated staff checked on the resident frequently and would encourage engagement with the staff as a preventative attempt to keep the resident from eloping. The nurse stated the facility assisted the resident with obtaining a mental health case worker and had the resident's psychotropic medications changed from oral form to injection form to increase compliance as the resident had poor medication compliance due to always being out of the facility. The nurse stated the resident denied any concerns about her care when asked.

During an interview, an unlicensed personnel staff member (ULP) stated the staff used a group chat text where they communicated the time a resident left the facility and when they returned so everyone could be aware of a resident's whereabouts. The ULP stated if a resident did not return within 24 hours, they filed a missing person's report. The ULP stated the resident was not good about telling staff when she was leaving or where she was going. The ULP stated the resident was complaint with bathing and cleaning up her room as needed but refused her medications. The ULP stated she checked on the resident frequently due to her history of leaving the facility.

During an interview, the licensed assisted living director (LALD) stated staff received education on each resident's care plan and received in person and online training on how to manage behaviors and mental health concerns. The LALD stated the staff kept track of the time a resident left the facility to monitor a safe time frame for their return. The LALD stated the resident was compliant with her cares and medication when she first came to the facility, but then became non-compliant with oral medications. The LALD stated he attended medical appointments with the resident as she allowed and communicated medication concerns to her provider. The LALD stated the resident's mental health provider switched her medication from oral to injection because the resident refused her psychotropic oral medication. The LALD stated the resident did not return to the facility following her last hospitalization as she needed a higher level of care.

During an interview, a family member stated the resident has heard voices in her head since she was thirteen years old and had anger issues. The family member stated the resident had a pattern of taking off from where she was at and had incidents where law enforcement became involved. The family member stated the resident attended therapy services but had no idea where the resident was now as the resident has not contacted her or any other family members.

The investigator attempted to contact the resident by phone via her last known phone number but was not able to reach the resident. The resident's family did not know her current location or whereabouts.

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: No, unable to contact.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility performed frequent safety checks on the resident, obtained a mental health provider for the resident, and followed changes to psychotropic medications.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36541	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDENVIEW HEALTHCARE SERVICES	1001 65TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: HL365416511C/HL365414941M On October 30, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL365416511C/HL365414941M, tag identification 730.	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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to document care interventions and actions taken by staff for a resident concern as required for 1 of 1 residents (R1) reviewed. R1 frequently left the facility; failing to return for cares and medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1's diagnosis included schizoaffective disorder and developmental disorder. R1's service plan dated February 2, 2024, indicated R1 received assistance with medication administration, meals and safety monitoring. R1's medical record indicated she was her own decision maker. R1's mental health care plan dated January 8, 2024, directed staff to encourage R1 to voice concerns, remain calm, to not argue with the resident, explain to R1 the importance of cares to improve health, offer choices, and speak to R1	0 730		

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0 730	Continued From page 3 calmly and respectfully to manage R1's behaviors. The staff were directed to perform safety checks every two hours and call 911 and the nurse in case of emergency. R1's home health aide care plan dated January 8, 2024, indicated staff were to complete wellness checks every two hours. R1's progress note dated July 4, 2024, the nurse noted R1's noncompliance with psychiatric medications due to being away from the facility so often and had planned to discuss with her medical provider and care team for intervention to help with medication adherence. R1's hospital record dated July 18, 2024, indicated R1 was found in the community, in a carwash, nude, except for a stolen shirt from the carwash business. R1 had uncontrollable body movement, difficulty talking and identifying herself. R1's hospital record indicated the facility had filed a missing person's report. Emergency medical services (EMS) transported her to the emergency department (ED) for evaluation. R1 was placed on a 72 hour hold awaiting inpatient mental health admission. A hospital note dated July 22, 2024, indicated a nurse practitioner who evaluated R1 spoke with the licensed mental health practitioner (LMHP) about a commitment and sent paperwork for a Jarvis (court ordered medication compliance) and sent it to the LMHP. R1's progress note dated July 22, 2024, indicated the nurse visited the facility to complete a 90 day assessment, but R1 was still at the hospital. R1's record lacked any documentation when R1 returned from the hospital.	0 730		

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0 730	Continued From page 4 R1's readmission assessment dated August 14, 2024, indicated R1's antipsychotic medication, clozapine, had been discontinued and Abilify monthly injection prescribed for medication compliance. Additionally, R1 would no longer need lab draws with the change in medications. The assessment did not include any interventions to promote R1's self safety of returning to the facility after leaving. R1's medication administration record dated August 1 through August 19, 2024, showed noncompliance with her psychiatric medications due to being away from the facility and refusal to take medications every day. Review of law enforcement reports from April 12, 2024 through August 21, 2024, reports were in response to the facility filing a missing person report, aside from one medical call response related to the facility calling law enforcement for assistance with violence. R1's service delivery record dated August 2024 indicated staff performed safety checks every morning, afternoon and night. The record lacked documentation of any interventions attempted to prevent R1 from leaving the facility and not returning. R1's hospital record dated August 23, 2024, indicated R1 had left the facility and been gone/missing for two days. R1's facility had filed a missing person's report. Law enforcement found R1 and EMS brought her to the ED for evaluation. The hospital record indicated R1 had a history of civil commitment, presently not on one and her last commitment ended March 10, 2022. R1 did not return to the facility after discharge.	0 730		

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0 730	Continued From page 5 R1's progress notes lacked any further documentation after July 22, 2024, including when the facility was filing missing person reports for R1 failing to return home, communication with R1's medical provider, attendance of facility staff to R1's medical appointments, and communication related to R1 with other individuals involved her care. R1's record also lacked documentation of R1's mental health concerns requiring a civil commitment and/or Jarvis order and intention to seek one after her hospital visit on July 18, 2024. R1's record lacked documentation of the plan for staff to file missing person reports when R1 left the facility and did not return within 24 hours. During an interview on November 7, 2024, at 12:00 p.m., licensed assisted living director (LALD)-E stated the facility did not have an sign in/sign out process for the residents when they leave the facility. LALD-E stated if a resident left the facility and did not return within 24 hours, they filed a missing person's report. LALD-E stated he attended appointments with R1 and informed her provider of her non-compliance with medications. staff would buy R1 the items she needed so she wouldn't go out to get them, and staff always checked on R1. During an interview on November 5th, 2024, at 12:00 p.m., activities coordinator (ACT)-B stated if R1 was gone from the facility for more than 24 hours, staff would file a police report for a missing person. ACT-B stated he would take R1 for a ride to the store or gas station when R1 was bored. ACT-B stated staff would check on R1 every 30 minutes when she would return from a hospital stay.	0 730		

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0 730	Continued From page 6 During an interview on November 7th, 2024, at 8:27 a.m., unlicensed staff (ULP)-D stated facility staff used a group chat to communicate times R1 left the facility and what time R1 returned. ULP-D stated if a resident was not back in 24 hours, they called 911 to report a missing person. ULP-D stated staff would check on R1 often and follow changes to her medications. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		