Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL345624163M
Compliance #: HL345627121C

Date Concluded: August 4, 2023

Name, Address, and County of Licensee Investigated:
SMC Ashton Inc.
7100 Northland Circle Suite #207
Brooklyn Park, MN 55445
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele R. Larson, 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 (resident #1) when they failed to provide adequate supervision and services for the resident. The resident overdosed on illegal drugs twice in one week in another resident's room (resident #2).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment for both resident #1 and resident #2. The facility failed to ensure adequate supervision was implemented after resident #1's first overdose. Resident #1's record indicated he required 1:1 staff support and supervision because of his self-injurious behaviors which included illegal drug use, yet his record did not indicate he received those services. Records indicated the facility was aware resident #2 kept illegal drugs in his room, yet facility staff allowed resident #1 to congregate in resident #2's room after his first overdose. Facility staff failed to implement the 1:1 supervision required for resident #2. In addition, both the facility neglected to ensure a safe location for resident #1 and resident #2 to discharge to.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed resident #1's case manager. The investigation included review of resident #1's facility medical record, hospital record, law enforcement reports, resident #2's record, employee files, and facility policies and procedures. Also, the investigator observed resident cares and interactions during her onsite investigation.

Resident #1

Resident #1 resided in an assisted living facility. His diagnoses included schizophrenia, bipolar disorder, and history of polysubstance abuse. He received assistance from staff for medication management, socialization, and behaviors related to wandering, anxiety, repetitiveness, verbal aggression, tobacco, and alcohol use. He received one safety check per shift. Resident #1's assessment indicated he was cognitively impaired and had poor decision-making skills. His record indicated he required 1:1 staff supervision and support due to poor judgement and impulsivity. Staff were to promptly report any signs of self-abuse to the facility nurse.

Resident #1's incident report indicated at 10:00 p.m., resident #1 was found unconscious in resident #2's room. Resident #2 called 911 and resident #1 was transported to a hospital.

Resident #1's law enforcement report indicated resident #1 was unresponsive in the same room another resident (resident #2) overdosed in one month earlier. They observed a white, powdery substance in his left nostril, and he had snorting, gasping breathing. Resident #2 said he administered an opioid reversal medication (Narcan) to resident #1 before law enforcement arrived. Emergency medical services (EMS) transported resident #1 to a hospital.

Resident #1's hospital record indicated he was diagnosed with acute respiratory failure with low oxygen (hypoxia) and required several doses of Narcan due to low oxygen levels. Resident #1 admitted he used cocaine when he was in resident #2's room. His drug screen tested positive for cocaine and amphetamines. Hospital doctors suspected he took a synthetic opioid (Fentanyl) that did not show up in his drug screen. Resident #1 was discharged back to the facility two days later with instructions to follow-up with his primary doctor and outpatient psychiatry as-soon-as possible.

The facility nurses failed to assess resident #1's after his overdose. Therefore, the facility also failed to identify and implement safety interventions to prevent a future overdose. Resident #1's service plan required 1:1 staff supervision, and monitoring, however his service delivery record lacked documentation staff performed tasks to monitor his self-injurious behaviors.

In addition, the facility staff did not intervene with resident #1's overdose and resident #2 administered Narcan and called 911.

Approximately eight days later, resident #1 overdosed again in resident #2's room. Facility staff called 911 and transported resident #1 to the hospital.

A law enforcement report indicated resident #1 was suspected of another drug overdose. Resident #2 told law enforcement resident #1 typically used a narcotic oral medication. Paramedics were able to resuscitate resident #1 while enroute to the hospital. After the emergency room visits, resident #1 returned to the facility.

The facility nurses failed to assess resident #1's after his second overdose and implement safety interventions. Resident #1's record lacked documentation the facility implemented 1:1 staff supervision and monitoring.

Facility records indicated resident #1 was in resident #2's room on several separate occasions, yet facility records lacked documentation staff tried to stop or redirect resident #1 from entering resident #2's room.

Later, the facility initiated an improper discharge and failed to identify who resident #1 was going to live with. The facility failed to identify the home resident #1 discharged to was able to meet his health and safety needs.

Resident #2

Resident #2's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), and amphetamine-type substance use disorder. Resident #2's behavioral plan indicated resident #2 required continuous monitoring throughout the day due to his high risk behaviors of impulsivity, mood changes, and illicit drug use.

Resident #2's progress note indicated sometime after 12:00 p.m., resident #2's girlfriend ran upstairs to alert staff to call 911 because resident #2 overdosed. Resident #2 was transported to the hospital and later returned to the facility.

The facility nurses failed to assess resident #2 after his overdose and implement further safety interventions to prevent another overdose.

Approximately one month later, the facility completed an assessment of resident #2. The assessment indicated resident #2 used drugs not prescribed by a physician but it did not indicate what non-prescribed drugs he specifically used. The section to assess resident #2's behaviors was left blank. The licensee nursing staff failed to accurately assess resident #2's need for continuous monitoring and supervision and failed to address his need for hourly safety checks.

Resident #2's service plan failed to include hourly safety checks for staff to implement.

The facility failed to develop a protocol for neither resident #1 nor resident #2 to obtain Narcan orders and when to administer for each resident who had a known history of drug use and overdoses.

Later, the facility initiated an improper discharge and told resident #2 after resident #1's second overdose he could no longer reside in the facility. The facility discharged resident #2 to homelessness and failed to coordinate a safe transfer to another facility or home where resident #2's health and safety needs could be met.

During an interview, the nurse stated all resident received two-hour safety checks unless instructed. The nurse stated a resident who overdosed would receive increased safety checks.

During an interview, the administrator stated the facility was a safe house and they did not allow residents who had an extensive drug history and actively used. The administrator stated although he had a conversation with resident #1's case manager about providing additional support for resident #1 until resident #2 moved out of the facility, it became difficult to "get things going" due to the passing of resident #1's guardian. The administrator said he did not know where resident #2 discharged to. The administrator stated resident #2 grabbed his items and left.

During an interview, ULP #1 stated safety checks were performed at the start of each shift to make sure they were alive, then after the initial check, residents were checked periodically. ULP #1 stated the rules of the facility were not to allow residents in another resident's room but stated resident #1 and #2 always "hung" out together. ULP #1 stated resident #2 always drank and smoked in his room even though residents were not allowed to do so. ULP #1 stated the cigarettes had a "funny smell" and were not really cigarettes. ULP #1 stated five people overdosed in resident #2's room, including resident #2. ULP #1 stated staff were not trained on how to administer Narcan to residents who overdosed, stating, "the police and 911 give them drugs."

During an interview, ULP #2 stated resident #1 wanted to do his own thing and would go into resident #2's room even if they told him not to. ULP #2 stated there would always be a lot of people in resident #2's room doing drugs and drinking.

During an interview, resident #1's case manager (CM) stated resident #1 had cognitive issues and was vulnerable to other people's persuasions. The CM stated she was frustrated with the facility for their lack of updates regarding resident #1's behaviors. The CM stated she found out about resident #1's overdoses from hospital emails. The CM stated she provided Narcan to the facility because they did not have any onsite. The CM stated resident #1 passed away from a Fentanyl overdose weeks after he moved out of the facility. The CM stated his death could have been preventable if the facility had increased supervision and monitoring.

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. Resident #1 is deceased. He died three weeks before the investigator initiated her onsite investigation. Resident #1 died from Fentanyl toxicity (drug overdose). Resident #2’s location was unknown.
Family/Responsible Party interviewed: Yes. Resident #1’s case manager was interviewed.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility took steps to terminate resident #2’s services to prevent other residents from potential future drug overdoses.

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
Brooklyn Park City Attorney

Brooklyn Park 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
	34562	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMC ASHTON INC	7435 78TH COURT NORTH BROOKLYN PARK, MN 55445

(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: #HL345627121C/#HL345624163M On May 31, 2023, 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 4 residents receiving services under the provider's Assisted Living license. The following correction orders are issued that were not issued at the time of immediate correction orders. The following correction orders are issued for #HL345627121C/#HL345624163M, tag identification 1040, 1130, 1620, 1640, 2310, 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.	
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required	01040		

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01040	Continued From page 1 (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice of termination for one of two residents (R2) with records reviewed. R2 was asked to leave the licensee's facility after R2 continued to be non-compliant with the facility's house rules, yet R2's record lacked documentation he was given a written notice of termination at least 30 days	01040		

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01040	Continued From page 2 ahead of the termination or at least 15 days ahead of an expedited termination. 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: R2's medical record was reviewed. R2 admitted to the licensee's facility on August 12, 2022. R2's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), and amphetamine-type substance use disorder. R2's Behavioral Plan, undated, indicated R2 was to receive continuous monitoring throughout the day due to R2's high risk behaviors of impulsivity, mood changes, and illicit drug use. R2's assessment dated November 18, 2022, indicated R2 required indirect supervision. R2 used drugs that were not prescribed by a physician. A document titled, Termination of Service Notification, indicated R2's expedited date of terminated services notification would be intimated December 14, 2022, and effective December 28, 2022. The termination of R2's services would be issued regardless of R2's early departure from the licensee's facility. The document indicated R2 would benefit from a higher level of inpatient services to manage his	01040		

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01040	Continued From page 3 drug dependency. The licensee would participate in R2's coordinated transfer of care to another health care provider or caregiver and would continue to provide services until another facility assumed care. The name and contact information for two facilities were listed on the last page of the document. Beneath the facilities names, the space for R2's signature and date was blank. R2's record lacked documentation the licensee issued R2 a notice of termination at least 30 days ahead of the proposed termination of 15 days ahead of an expedited termination. During an interview on June 7, 2023, at 10:00 a.m., administrator (A)-D stated he was unsure but he thought the licensee gave R2 a termination notice in October or November 2022, before R1's December overdoses. A-D stated the license must wait for a period of time whenever a termination notice was given to a resident. A-D stated R2 moved out before the termination notice was given to him. A-D stated he did not know where R2 went, stating, "[R2] self-discharged. He grabbed his things and moved out." The licensee policy titled Discharge and Transfer of Residents, dated August 1, 2021, indicated prior to issuing a notice of termination, the licensee would schedule and participate in a pre-termination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss the reasons for the proposed termination and to identify and offer reasonable accommodations, modifications, or other alternatives to avoid the termination. A written notice for the meeting would be provided to the resident and the resident's representative	01040		

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01040	Continued From page 4 at least five business days in advance. A pre-termination meeting would be scheduled to take place at least seven days before a notice of termination was issued. The licensee would make a reasonable effort to ensure the resident and their representatives were able to attend. TIME PERIOD TO CORRECT: Seven (7) days.	01040		
01130 SS=H	144G.55 Subd. 2 Safe location A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a safe discharge location or adequate and needed service provider was identified for two former residents (R1, R2) with records reviewed. The licensee allowed R1 to self-discharge to move into an unknown family member's home. R2 moved out of the licensee's facility to an unknown location. 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	01130		

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01130	Continued From page 5 serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Minnesota (MN) Statute 144G.55, Subd. 2, Safe Location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as a result of the termination, become homeless, as that term is defined in section 116L.361, Subd. 5, or if an adequate and unsafe discharge location or adequate and needed service provider has not been identified. R1 R1's medical record was reviewed. R1 admitted to the licensee's facility on August 1, 2021. R1's diagnoses included schizophrenia, bipolar, depressive episodes, and anxiety. R1's individual abuse prevention plan (IAPP) dated November 22, 2022, indicated R1 had a history of substance abuse. R1 was vulnerable to chronic pain, inability to report abuse, neglect, exploitation, and being abused by other individuals, including other vulnerable adults. R1's assessment dated November 22, 2022, indicated R1 used recreational drugs and was cognitively impaired with poor decision-making skills. R1's behavioral plan, undated, indicated R1 had	01130		

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01130	Continued From page 6 no awareness of time and place, and was unable to adequately express his needs due to his limited communication skills. R1 would leave the facility and go to dangerous, unsafe places in the metro, and return under the influence of unknown substances. R1 was diagnosed with schizophrenia and was likely to have future episodes requiring treatment of a frequency of two or more hospitalizations in the past 24 months or continuous psychiatric hospitalization/residential treatment exceeding six of the last twelve months. R1 was committed as mentally ill under MN Statute 253B.18. R1 required constant supervision when out in the community. R1 was to receive 1:1 staff support and supervision to maintain his safety. R1's service plan dated January 13, 2023, indicated R1 received assistance with medication management, meals, personal cares, laundry, housekeeping, and a daily safety check. R1's incident report dated March 6, 2023, documented by unlicensed personnel (ULP)-E, indicated R1 told ULP-E he was moving out but would not give ULP-E a reason why. R1's family member (name unknown) was notified. ULP-E contacted administrator (A)-D and told him about R1 moving out of the licensee's facility. ULP-E documented A-D instructed if R1 wants to leave, staff should let him go, so ULP-E let R1 leave. R1's progress note dated March 7, 2023, indicated R1 was absent from the licensee's facility. Staff documented R1 was on a leave of absence (LOA). R1's progress note lacked documentation the licensee knew R1's whereabouts.	01130		

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01130	Continued From page 7 A document titled Discharge Summary, indicated on March 16, 2023, R1 self-discharged to "home," indicating R1 moved in with an unknown brother. The document did not list R1's brother name, phone number, or address. R1's progress note dated March 18, 2023, indicated staff documented R1 was still LOA with unknown family members. R1's progress note dated March 24, 2023, indicated staff documented R1 was still on LOA. R1 was still with family. R1 stopped by to pick up his things and to be discharged. R1's record lacked documentation the licensee identified an adequate and safe discharge location or adequate and needed service provider for R1. R1's record lacked documentation the licensee performed an assessment on R1's unknown family members and their residence to ensure R1's family could meet R1's needs and services. R2 R2's medical record was reviewed. R2 admitted to the licensee's facility on August 12, 2022. R2's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), and amphetamine-type substance use disorder. R2's Behavioral Plan, undated, indicated R2 was to receive continuous monitoring throughout the day due to R2's high risk behaviors of impulsivity, mood changes, and illicit drug use. R2 engaged in high-risk behaviors which included drug and cannabis use. Staff would receive a mandatory care plan and service orientation before providing services to R2. Staff were to receive training on behavioral redirection for R2's agitation,	01130		

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01130	Continued From page 8 screaming, yelling, and resistance to cares. R2's assessment dated November 18, 2022, indicated R2 required indirect supervision. R2 used drugs that were not prescribed by a physician. R2 was unable to safely self-administer his medications. R2's IAPP dated November 22, 2022, indicated R2 had a history of substance abuse and was at risk for abusing other vulnerable adults. R2's document titled, Notice of Pre-termination Meeting, indicated a proposed pre-termination meeting was scheduled for December 9, 2022, at 1:00 p.m. The licensee indicated they wanted to terminate R2's services based on the following: bringing multiple people into the facility at one time; failing to follow visitation rules; residents overdosing on illegal drugs while in R2's room; refusing room searches; smuggling drugs into the facility. On November 12, 2022, the licensee failed to schedule a pre-termination meeting due to a schedule conflict with R2's case manager. R2's progress note dated December 12, 2022, indicated R2 called staff after another resident (R1), "passed out" and needed help. At 3:00 p.m., staff was informed R2 he could no longer resided in the facility. R2's discharge summary dated December 12, 2022, at 5:00 p.m., indicated R2, "left alone with all his belongings and medications after [R1] was found unresponsive in R2's room. R2 became anxious and started to move his belongings out." R2's progress note dated December 13, 2022, indicated R2 was in his room when staff arrived to work the morning shift. Staff told R2 the manager	01130		

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01130	Continued From page 9 wanted R2 to move out today. R2's progress note dated December 13, 2022, at 11:00 p.m. indicated administrator (A)-D and "other people" were in the house. Law enforcement arrived and took R2 away but returned R2 to the facility. Staff documented at 4:12 a.m., R2 was in the room sleeping. R2's progress note dated December 14, 2022, indicated R2 was in his room when staff arrived to work the morning shift. The staff member told R2 he needed to leave the facility. R2 indicated he had a 9:00 a.m. appointment and would leave the facility after his appointment. R2 left the facility at 12:00 p.m. in a vehicle with an unknown person to an unknown destination. R2's Termination of Service Notification, dated December 14, 2022, indicated R2's expedited date of terminated services notification would be initiated December 14, 2022, and effective December 28, 2022. The termination of R2's services would be issued regardless of R2's early departure from the licensee's facility. The document indicated R2 would benefit from a higher level of inpatient services to manage his drug dependency. The licensee would participate in R2's coordinated transfer of care to another health care provider or caregiver and would continue to provide services until another facility assumed care. The name and contact information for two facilities were listed on the last page of the document. At the bottom of the document, the space for R2's signature and date was blank. R2's termination notice was dated the same day R2 was told he had to move out of the facility.	01130		

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01130	Continued From page 10 R2's record lacked documentation the licensee identified an adequate and safe discharge location or adequate and needed service provider for R2. On June 1, 2023, at 12:00 p.m., registered nurse (RN)-C stated R2 never had a pre-termination meeting, stating R2 panicked and left before the meeting was held. In addition, RN-C stated R2's departure from the licensee's facility was not coordinated with another facility, stating R2 would not state where he was going. RN-C stated, he may have said something to A-D, but did not know. The licensed practical nurse (LPN) would have been involved with his discharge. On June 7, 2023, at 10:00 a.m., A-D stated R1 refused the redirection the facility was giving him and refused to go and see a psychiatrist. A-D stated to the best of his knowledge he thought R1 moved in with a family member. A-D stated he did not know where R2 went, stating, "[R2] self-discharged. He grabbed his things and moved out." During an interview on July 13, 2023, at 8:33 a.m., R1's case manager (CM)-G stated R1 passed away from a Fentanyl overdose weeks after he moved out of the facility. The licensee policy titled Discharge and Transfer of Residents, dated August 1, 2021, indicated prior to issuing a notice of termination, the licensee would schedule and participate in a pre-termination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss the reasons for the proposed termination and to identify and offer reasonable accommodations, modifications, or other alternatives to avoid the termination. A	01130		

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01130	Continued From page 11 written notice for the meeting would be provided to the resident and the resident's representative at least five business days in advance. A pre-termination meeting would be scheduled to take place at least seven days before a notice of termination was issued. The licensee would make a reasonable effort to ensure the resident and their representatives were able to attend. If a resident voluntarily discharged, and the resident continued to need health-related services, the licensee would assist a resident to access home care or alternative services by providing a list of appropriate providers in the area to the resident or the resident's representatives. TIME PERIOD TO CORRECT: Seven (7) days.	01130		
01620 SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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	01620		

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01620	Continued From page 12 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 ensure a registered nurse (RN) performed reassessments for two of two residents (R1, R2) with records reviewed. R1 overdosed twice in one week on illegal substances while in R2's room. R1 was revived both times with an opioid reversal drug (Narcan) and admitted to a hospital. In addition, the licensee failed to ensure R2 was accurately assessed by an RN to reflect an increase in needs. R2 was assessed as requiring indirect supervision despite the licensee's documentation that R2 required continuous monitoring. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's medical record was reviewed. R1 admitted to the licensee's facility on August 1, 2021. R1's diagnoses included schizophrenia, bipolar, depressive episodes, and anxiety.	01620		

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01620	Continued From page 13 R1's service plan indicated R1 was to receive assistance with medication management, meals, personal cares, laundry, housekeeping, and a daily safety check. R1's admission assessment dated August 1, 2021, indicated R1 used unknown recreational drugs not prescribed by a physician. R1's individual abuse prevention plan (IAPP) dated November 22, 2022, indicated R1 had a history of substance abuse. R1 was vulnerable to chronic pain, inability to report abuse, neglect, exploitation, and being abused by other individuals, including other vulnerable adults. R1 drank alcohol sanitizer. R1's progress report dated December 4, 2022, indicated R1 was found unconscious in another resident's (R2) room. R2 called 911. R1 was transported to a hospital. R1's law enforcement report dated December 4, 2022, at 10:15 p.m., indicated law enforcement were dispatched to the licensee's facility after R2 called 911 to report R1 was overdosing in R2's room. R2 told law enforcement R1 overdosed while snorting cocaine. R2 stated he administered Narcan to R1 prior to law enforcement's arrival. Law enforcement observed R1 had a white, powdery substance in R1's left nostril, irregular breathing (agonal), and vomit on his body. R1 was transported to a hospital. R1's progress note dated December 6, 2022, indicated at 6:02 p.m., R1 returned to the facility after his discharge from the hospital. R1's record lacked documentation R1 was reassessed by an RN after he was discharged	01620		

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01620	Continued From page 14 from the hospital and implemented interventions to prevent further drug abuse/overdose. R1's progress note dated December 12, 2022, indicated between 7:00 a.m. and 3:00 p.m., R1 "passed out," after he walked to another resident's room. Staff called 911. R1 was transported to a hospital but returned later that day. R1's law enforcement report dated December 12, 2022, at 11:52 a.m., indicated R1 was unresponsive from a possible drug overdose while in R2's room. R2 told law enforcement R1 became unconscious shortly after he walked into R2's room. R2 stated he did not see R1 use any drugs that day but stated R1 typically used Percocet. Paramedics were able to get R1 to breathe on his own while enroute to the hospital. R1 returned back to the facility the same day. R1's record lacked documentation R1 was reassessed by an RN after his drug overdose and evaluated after his emergency room visit. R2 R2's medical record was reviewed. R2 admitted to the licensee's facility on August 12, 2022. R2's diagnoses included major depressive disorder, Post-Traumatic Stress Disorder (PTSD), and amphetamine-type substance use disorder. R2's Behavioral Plan, undated, indicated R2 was to receive continuous monitoring throughout the day due to R2's high risk behaviors of impulsivity, mood changes, and illicit drug use. R2 engaged in high-risk behaviors which included drug and cannabis use. Staff providing R2's services would receive a mandatory care plan and service orientation before providing services to R2. Staff	01620		

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01620	Continued From page 15 were to receive training on behavioral redirection for R2's agitation, screaming, yelling, and resistance to cares. R2's progress note dated October 22, 2022, indicated sometime after 12:00 p.m., R2's girlfriend ran upstairs to alert staff to call 911 because R2 overdosed. 911 arrived and took R2. R2 later appeared outside of the facility with law enforcement. An email dated October 24, 2022, at 12:58 a.m., from administrator (A)-D to R2's case manager, indicated R2's verbal aggression increased dramatically. R2 continued to bring multiple friends into the facility late at night then leave the facility for hours at night. A-D would review the facility's visitation policy with R2. An email dated November 10, 2022, at 11:53 a.m., from A-D to R2's case manager indicated on November 9, 2022, a resident overdosed in R2's room. Paramedics transported the resident to a hospital. The facility indicated multiple people from the community were in and out of R2's room daily. The facility indicated they would initiate an internal investigation. R2's record lacked documentation the facility conducted an investigation relating to the drug overdose. R2's assessment dated November 18, 2022, indicated R2 was alert and oriented to person, place, and time. R2 was unable to safely self-administer his medications. R2 used drugs not prescribed by a physician but it did not indicate what non-prescribed drugs he specifically used. The section to assess R2's behaviors was left blank. The licensee nursing staff failed to	01620		

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01620	Continued From page 16 accurately assess R2's need for continuous monitoring and supervision, and failed to address his need for hourly safety checks. During an interview on June 1, 2023, at 12:00 p.m., registered nurse (RN)-C stated nurses assigned to each of the licensee's facilities were in charge of performing resident assessments. The licensee's policy titled Assessment and Reassessment, dated August 1,2 021, indicated ongoing resident reassessments must be conducted by an RN. Ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within the scope of their licenses. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 17 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately document services provided for one of two residents (R1) with records reviewed. Unlicensed personnel (ULP) documented they provided services for R1 while is was in the hospital for two days due to a drug overdose. 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 R1's medical record was reviewed. R1 admitted to the licensee's facility on August 1, 2021. R1's diagnoses included schizophrenia, bipolar, depressive episodes, and anxiety. R1's initial service plan dated August 1, 2021, indicated R1 received assistance with medication management, meals, laundry, housekeeping, and one safety check per shift.	01640		

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01640	Continued From page 18 R1's individual abuse prevention plan (IAPP), dated November 22, 2022, indicated R1 had a history of substance abuse. R1 was vulnerable to chronic pain, inability to report abuse, neglect, exploitation, and being abused by other individuals, including other vulnerable adults. R1's assessment dated November 22, 2022, indicated R1 was cognitively impaired with poor decision-making skills. R1's behavioral plan, undated, indicated R1 had no awareness of time and place, and was unable to adequately express his needs due to his limited communication skills. R1 required constant supervision when out in the community. R1 was to receive 1:1 staff support and supervision to maintain his safety. R1's progress report dated December 4, 2022, indicated R1 was found unconscious in another resident's (R2) room. Staff called 911 and R1 was transported to the hospital. R1's progress note dated December 6, 2022, indicated at 6:02 p.m., R1 returned to the facility after his discharge from the hospital. R1's service delivery record dated December 2022, indicated staff completed the following tasks: laundry, housekeeping, meals, personal cares, medication administration, 1:1 and group socialization with other residents, in-home activities, repetitive behaviors, and wandering. R1's service delivery record indicated between December 4, 2022, at 10:00 p.m. and December 6, 2022, at 6:00 p.m., unlicensed personnel falsely documented they performed the following tasks:	01640		

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01640	Continued From page 19 12/5/22: Meals & Snacks (8:00 a.m., 12:00 p.m., 3:00 p.m. 5:00 p.m., 8:00 p.m.); (bathing, dressing, grooming reminders (a.m./p.m.); medication administration (8:00am, 12:00 p.m., 4:00 p.m., 8:00 p.m.); group socialization; in-home activities; wandering; repetitive behaviors. 12/6/22: Meals & Snacks (8:00 a.m., 12:00 p.m., 3:00 p.m. 5:00 p.m.); (dressing, grooming reminders (a.m./p.m.); medication administration (8:00am, 12:00 p.m., 4:00 p.m.); group socialization; in-home activities; wandering; repetitive behaviors. On June 1, 2023, at 12:00 p.m., registered nurse (RN)-C stated RN's who were assigned to the facilities were responsible for developing the resident's service plans. The licensee policy titled Service Plan, dated August 1, 2021, indicated service plans would be implemented for all residents. TIME PERIOD OF CORRECTION: Seven (7) Days	01640		
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 two of two resident(s) reviewed (R1, R2) were free from maltreatment.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 20 Findings include: 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		