Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350072805M
Compliance #: HL350074682C

Date Concluded: March 16, 2023

Name, Address, and County of Licensee Investigated:
Midwest Homes INC
2445 10th Avenue South
Minneapolis MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), an unlicensed caregiver, neglected the resident when he brought the resident to the bar and drove her home intoxicated.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to incomplete and conflicting accounts of what occurred it could not be determined if maltreatment occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included a review of the resident's records, the AP's personnel record, the facility's policies, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident's diagnoses included borderline personality disorder and anxiety disorder. The resident's service plan included requires supervision, cuing for activities of daily living, monitoring, and redirecting as needed for mental health needs.

During an interview, the resident stated the AP took her out for a drink, and another unlicensed caregiver from the facility joined them at the bar. The resident stated they drank together and then the AP dropped her off at the facility later the same evening. The resident stated she was unable to provide further information regarding the day, time, or location these events occurred. She stated she told the director about it, but the director told her not to tell anyone. The resident stated this occurred more than once. The resident stated she had to go to places like this even if she did not want to because she always had to be under facility staff member supervision.

During an interview, the AP stated he did take residents from the facility to locations like the mall, doctor's appointments, and restaurants if requested. The AP stated he did not take the resident to a bar or drink with her.

During an interview, the resident's social worker stated she visited the resident at the facility and the resident told her about going to a bar, getting drunk, and returning to the facility. The social worker stated she told the director, but the director said she did not know anything about it. The social worker stated the resident said it had happened a couple of weeks prior but could not provide any more specific information.

During an interview, the director stated she learned about the resident's concerns two weeks after the AP's employment ended at the facility from a "case manager" but could not recall the name of the "case manager". The director stated the resident never told her about the drinking with the AP. The director stated the resident ended up leaving the facility for reasons unrelated to the investigation about the same time so she did not get a chance to talk the resident about it.

During the investigation, the investigator identified the "case manager" as the same person as the unlicensed care giver the resident said joined the AP and her at the bar. The investigator attempted multiple times to reach this person but was unsuccessful.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	35007	A. BUILDING: _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 On January 31, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL350074682C/ HL350072805M. No correction orders are issued.	0 000		