DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357287062M
Compliance #: HL357281780C

Date Concluded: March 24, 2025

Name, Address, and County of Licensee Investigated:
Epic Homes
1800 Laramie Trail
Brooklyn Park, MN 55444
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 to ensure an intoxicated resident remained safe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The resident was found in the community multiple times by law enforcement, intoxicated and returned to the facility. This led to the resident being found unconscious and barely breathing, outside of a local gas station. The resident required Narcan (medication to rapidly reverse lift threatening opioid overdose) and emergency transportation to a hospital and was hospitalized for 26 days. The facility knew about the resident's alcohol use and failed to assess and implement interventions to ensure the safety of the resident.

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

county case manager. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, bipolar disorder, and depression. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident had intact cognition and was independent with activities of daily living. The resident's abuse prevention plan indicated the resident had psychotic behaviors, refused medications, and left the facility and returned intoxicated. The plan lacked evidence of interventions for the resident's alcohol intake.

The resident's progress notes indicated the resident would come and go from the facility. At times, staff were unaware when the resident left the facility and would attempt to call his phone. The resident would turn his phone off. The progress notes indicated the resident had known behaviors of returning to the facility heavily intoxicated and refusing his medications.

One day law enforcement found the resident sitting on the curb of a sidewalk, with his legs in the street and his head slumped over the sidewalk. Law enforcement indicated the resident stated he had explosives implanted in his head and in his back by a doctor. The resident walked around the community and was scared of the voices inside his head. The resident returned intoxicated to the assisted living.

The next day, a law enforcement report indicated the resident was found intoxicated, laying on the ground in a parking lot, yelling, gazing into space and not aware of his surroundings. Law enforcement transported the resident back to the assisted living.

The following day, law enforcement found the resident intoxicated, unconscious outside in a parking lot, laying in a puddle, saturated with water, an outside temperature of 42 degrees Fahrenheit, with agonal breathing (gasping and labored), and a bottle of alcohol next to him. The resident's eyes were slightly open and rolled to the back of his head. The resident responded to a dose of Narcan provided by law enforcement. When the resident woke up, the resident was noncommunicative, his eyes were dilated, and he was flailing his arms and screaming. Once emergency medical services arrived, the resident was placed in the ambulance. The resident continued to be nonverbal, screaming, shaking his arms and extremely cold. Heat packs were used to warm the resident, and he was transported to the hospital. The law enforcement report indicated there was concerns that the resident could be seriously injured or die because of the times law enforcement had found the resident in high traffic roadways, and in the cold and rain.

Hospital records indicated the resident was hospitalized and treated for alcohol withdraw and psychosis (a mental health condition characterized by a loss of contact with reality). On admission to the hospital, the resident's blood alcohol level was 0.402 (normal blood alcohol

0.00 % to 0.05%). A blood alcohol level above 0.20 was extremely dangerous, potentially fatal, could possibly cause a coma, respiratory depression, and death. After 26 days, the resident's mental health stabilized, and the resident was discharged from the hospital to the assisted living facility.

The resident's medical record lacked evidence the facility attempted to update the resident's physician about increased mental health concerns, alcohol intake, and refusal of medications. The resident's medical records lacked evidence the facility assessed and developed interventions for the resident's known alcohol use and medication refusal.

During an interview, a nursing assistant stated prior to the hospitalization, the resident drank alcohol and would not take his medications. When the resident left the facility, staff would ask the resident where he was going and when he planned on returning. If the resident did not return at the time he stated, staff would call leadership, and leadership would go out into the community, find the resident and bring him back to the facility. If leadership could not find the resident, then law enforcement was notified, and law enforcement would bring him back.

During an interview, leadership stated shortly after the resident was admitted to the facility, he began refusing his medications, spiting his medications out, and drinking alcohol. Leadership stated when the resident's behaviors or hallucinations started, staff would do breathing exercises with him or take him for a ride around the community. Due to the resident's refusals, unsuccessful attempts were made to get the resident established with a primary care provider.

During an interview, a case manager stated it was the facility's understanding the resident had a history of alcohol and drug abuse. At the time of the admission to the facility, it was the understanding that the resident was sober and needed assistance with medication management.

In conclusion, the Minnesota Department of Health determined neglect was not 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.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility requested local liquor stores not to sell alcohol to the resident. When the resident would not return to the facility, staff would go look for the resident and if not found, the facility would notify the local law enforcement. Law enforcement would find the resident and return the resident to the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35728	A. BUILDING: _____ B. WING _____	C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIC HOMES LLC	1800 LARAMIE TRAIL BROOKLYN PARK, MN 55444

(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: #HL357287062M / #HL357281780C On March 4, 2025, 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 for #HL357287062M / #HL357281780C, tag identification 0630 and 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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess for individualized interventions to prevent self-harm for a resident with a known history of alcohol/drug abuse for one of one resident (R1) reviewed. R1 was found unconscious outside of a gas station intoxicated and required Narcan (medication to reverse opioid overdose) and a hospitalization for alcohol withdraw and psychosis (a mental health condition characterized by a loss of contact with reality). 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 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 face sheet indicated R1 admitted to the	0 630		

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0 630	Continued From page 2 licensee on September 23, 2024. R1's diagnoses included schizophrenia, bipolar disorder, depression, anxiety, delusional thoughts, hallucinations, and paranoid behavior. R1's initial assessment dated September 23, 2024, indicated R1 was alert, forgetful, wandered and had impaired decision making. The assessment indicated R1 drank alcohol and used illicit drugs. R1's Individual Abuse Prevention Plan (IAPP) dated September 23, 2024, indicated R1 had substance abuse concerns. The IAPP indicated staff were to monitor R1 24 hours a day and seven days a week. The IAPP indicated the liquor stores were asked not to sell liquor to R1 and that if R1 failed to return to the licensee by six in the evening, staff were to call the law enforcement. R1's care plan dated September 24, 2024, indicated R1 had psychosis concerns and would wander out of the facility and become intoxicated. R1's care plan included interventions of removing R1 from chaotic environments, ensure R1's safety, distract R1, and assist R1 with recognizing triggers for substance abuse. R1's behavior plan dated September 27, 2024, failed to identify R1's alcohol use and interventions to ensure R1's safety. R1's progress notes dated October 2, 2024, indicated emergency services were called when R1 was discovered outside screaming and walking in circles. R1 was transported to an emergency room. R1's room had several cans of opened and unopened beer and R1's fridge was half full and the trash was full to maximum	0 630		

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0 630	Continued From page 3 capacity with beer cans. R1's medical record lacked interventions for alcohol use following October 2, 2024, incident. R1's progress note dated October 13, 2024, indicated R1 "not doing well and [R1] need follow up." R1's progress note dated October 17, 2024, indicated a family member took R1 to the hospital and was brought back to the licensee. The progress note indicated "[R1] is not fine [R1] need follow up." R1's progress notes dated October 22, 2024, indicated R1 left the facility without notifying staff, law enforcement returned R1 to the licensee intoxicated. R1's medical record lacked evidence of updated interventions following October 22, 2024, incident. R1's progress note dated October 24, 2024, R1 was returned to the licensee by law enforcement intoxicated. R1's left the licensee again at 2 p.m. without notifying staff. R1's progress note dated October 25, 2024, indicated R1 returned to the licensee by staff and law enforcement at 10:45 p.m. on October 24, 2024. R1's medical record lacked evidence of updated interventions following October 24, 2024, incident. R1's progress note dated October 26, 2024, indicated R1 was found by licensee staff walking outside soaking wet and limping at 10:56 p.m. R1 was returned to the licensee.	0 630		

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0 630	Continued From page 4 R1's progress note dated October 30, 2024, indicated R1 left the licensee without notifying staff. R1 was returned to the licensee by staff at 10:25 p.m. R1 was running up and down the street yelling and screaming, saying staff were going to kill him. Law enforcement arrived at licensee, R1 calmed down. R1's progress note dated October 31, 2024, indicated R1 was intoxicated on October 30, 2024, and could not find his way back to the licensee. The progress note indicated R1 was returned to the licensee by law enforcement. R1's medical record lacked evidence of updated interventions following October 30, 2024, incident. R1's progress note dated November 2, 2024, indicated R1 left the licensee at 5 p.m. without notifying staff and returned at 10 p.m. The progress note indicated R1 had behaviors of coming back to the licensee heavily intoxicated. R1's medical record lacked evidence of updated interventions for behaviors of known intoxication. R1's progress note dated November 7, 2024, indicated R1 left the licensee without notifying staff, when staff attempted to call R1, R1's phone was turned off. R1's progress note dated November 8, 2024, indicated R1 left the licensee at 8:15 p.m. and had not returned to the licensee at 10:10 p.m. R1 would not answer his phone. R1's progress note dated November 10, 2024, indicated R1 left the licensee at noon without notifying staff.	0 630		

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0 630	Continued From page 5 R1's progress note date November 11, 2024, indicated R1 was returned to the licensee by law enforcement. Law enforcement report dated November 11, 2024, indicated R1 was found at 3:21 p.m. on a sidewalk with his head slumped over and his legs sticking out into the street. R1 told law enforcement that a doctor had implanted explosives inside his head and back. Law enforcement returned R1 to the licensee. R1's medical record lacked evidence of updated interventions following the incident on November 11, 2024. A law enforcement report dated November 12, 2024, indicated R1 was found at 7:00 p.m. at a middle school intoxicated. Law enforcement transferred R1 back to the licensee. R1's medical record lacked evidence of updated interventions following the incident on November 12, 2024. A law enforcement report dated November 13, 2024, indicated R1 was found at 7:19 p.m. outside of a gas station unconscious with a bottle of alcohol next to him. Law enforcement administered Narcan (is a treatment designed to rapidly reverse the effects of a life-threatening opioid emergency) and R1 woke up. R1 was transported to the hospital. R1's hospital record indicated R1 was hospitalized for 26 days and treated for alcohol withdraw and psychosis (a mental health condition characterized by a loss of contact with reality). The resident's blood alcohol level was	0 630		

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0 630	Continued From page 6 .402 (a blood alcohol content of 0.21 and higher is life-threatening alcohol poisoning.) During an interview on March 4, 2025, at 9:34 a.m., licensed assisted living director (LALD)-B stated shortly after the resident was admitted to the facility, he began refusing his medications, spiting his medications out and drinking alcohol. Leadership stated the facility was attempting to start an Invega injection (can treat schizophrenia and schizoaffective disorder) for the resident but was having difficulty establishing health insurance for the resident. Leadership stated when the resident's behaviors or hallucinations started, staff would do breathing exercises with him or take him for a ride around the community. At times the interventions worked for the resident and at times, the resident would run from staff out into the community, where they would go find him and try to get him to come back to the facility. In addition, the facility attempted to make physician appointments however, R1 would refuse the appointments. The licensee's Vulnerable Adult Maltreatment Prevention and Reporting policy dated September 24, 2024, indicated the licensee will develop an individualized vulnerable adult abuse prevention plan to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. TIME PERIOD OF CORRECTION: Seven (7) days.	0 630		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 7 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, 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		