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 #: HL361577704M**
**Compliance #: HL361574461C**

**Date Concluded:** July 30, 2024

**Name, Address, and County of Licensee Investigated:**
Caring Hearts Home Care Inc.
2916 Bloomington Ave S.
Minneapolis, MN 55407
Hennepin County

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

**Evaluator's Name:** Yolanda Dawson, RN
Special Investigator
**Reconsideration Analyst:** Jacci Nickell

**Finding:** Inconclusive

**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 when there was lack of supervision regarding his vulnerability to wander and substance abuse. The resident was found unresponsive in his room and paramedics were unsuccessful in reviving the resident.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect of supervision was inconclusive ~~substantiated~~. The facility was responsible for the maltreatment. The facility was aware the resident had a history of drug abuse. Multiple staff stated they suspected the resident currently abused substances. The resident's care plan indicated the resident required twenty-four-hour supervision for wandering. ~~Facility staff failed to implement interventions to keep the resident safe from having access to illicit drugs by allowing the resident to leave the facility late at night without supervision.~~

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical examiner documents, law enforcement records, resident records, and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included a history of substance abuse, schizophrenia, and depression. The resident's service plan included assistance with medication administration and behavior monitoring. The resident's assessment indicated staff would monitor the resident for drug abuse and unusual behavior related to drug use. Also, the resident was assessed for wandering behavior and staff were directed to accompany the resident to every appointment, outing, and errand, and have staff around 24 hours a day, seven days a week. Also, the house was equipped with 24-hour camera and motion detection alarm system.

The resident's record indicated the resident was vulnerable to self-abuse, alcohol abuse, chemical and or other medication abuse. Staff direction for the vulnerably included the resident avoiding the use of alcohol or other chemicals while residing at the facility and staff were to report any use to the nurse promptly. The goal and outcomes were that the resident would remain free of illegal drugs and staff would monitor risky behaviors with prescription medications.

One morning, a staff member went into the resident's room to wake him, and he did not respond, 911 and the nurse were called. The paramedics were unable to revive the resident. Law enforcement searched the room and found Fentanyl (opioid) that was not prescribed to the resident.

The facility's internal investigation document indicated the resident had the freedom to leave the facility on his own, giving him the opportunity to acquire drugs and bring them into the facility without anyone knowing. The document indicated the resident controlled every measure of his personal autonomy; therefore, he continued in his behavior of wandering the streets and using drugs, despite the facility's efforts to assist with redirecting him daily. This document contradicted the nursing assessment requiring the resident to be supervised at all times. The resident often left the facility for late-night walks. Staff questioned his drug use upon his return, but he always denied using drugs. The resident would sleep late in the morning after staying up late at night.

Law enforcement records indicated the drug Fentanyl was found in the resident's room.

The Medical Examiners record indicated the cause of the resident's death was combined Fentanyl and methamphetamines toxicity.

During an interview unlicensed personnel stated the resident would take late-night walks around midnight to one o'clock a.m. The unlicensed personnel stated he did not suspect the resident was abusing substances because he did not behave like he was using drugs. However,

staff and other residents believed that he was using drugs because of his late-night walks. The unlicensed personnel stated the resident's case manager was aware the resident was abusing drugs.

During an interview, a facility director stated she knew the resident was using drugs because of how he looked, and he would tell them that he was. The director stated she received calls from staff that the resident was high, and this was reported to the case manager.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive ~~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, deceased.
**Family/Responsible Party interviewed**: No, all family in Africa.
**Alleged Perpetrator interviewed**: Not applicable.

**Action taken by facility:**
The facility activated the emergency medical system, which included paramedics, police officers and the medical examiner. An internal investigation was conducted by 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
Minneapolis City Attorney
Minneapolis Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36157 | A. BUILDING: _____ B. WING _____ | C 12/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARING HEARTS HOME CARE INC | 2916 BLOOMINGTON AVENUE MINNEAPOLIS, MN 55407 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL361574461C/#HL361577704M<br><br>On December 21, 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 5 residents receiving services under the provider's Comprehensive Assisted Living license. The following correction order is issued that were not issued at the time of immediate correction orders.<br><br>The following correction order is issued/orders are issued for HL361574461C/#HL361577704M, tag identification 0730 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 02360 SS=G | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, | 02360 | | |

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| 02360 | Continued From page 1<br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | No plan of correction required. | |