Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373226903M
Compliance #: HL373221378C

Date Concluded: March 19, 2025

Name, Address, and County of Licensee Investigated:
Bright Path Homes
6604 Central Ave NE
Fridley, MN 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
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 residents (Resident #1 and Resident #2) when the residents were left alone in a closed facility bedroom. Resident #1 inhaled from a vape-inhaler that contained THC, (tetrahydrocannabinol which is the primary psychoactive compound found in cannabis (marijuana) plants) and cocaine which resulted in Resident #1 to become excessively drowsy and be transported to the hospital via ambulance.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although THC and cocaine were found in Resident #1's system, when staff observed a significant change in the resident's condition, the resident was sent to the emergency room for evaluation. Following the incident, staff implemented additional supervision to ensure the safety of the residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case workers and

guardian. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the facility environment, medication administration and staff interactions.

Resident #1 resided in an assisted living facility. The resident's diagnoses included chronic pain, anxiety and substance abuse. The resident's service plan included assistance with activity assistance three times per day, mobility assistance five times per day, medication management three times per day and shopping assist two times per day. The resident's assessment indicated she was alert and orient to person, place and time, with increased drowsiness after administration of ordered Clonazepam (a drug to promote relaxation). The resident's medical records indicated the resident had a Methadone prescription (a medication used to treat an opioid use disorder) and visited a Methadone Clinic every other week to assist in treatment for substance abuse.

Resident #2 resided in an assisted living facility. The resident's diagnosis included schizophrenia, depression and substance abuse. The resident's service plan included assistance with dressing in the morning, behavior monitoring three times per day, medication management, and shopping assistance one day per week. The resident's assessment indicated he was alert and orient to person, place, and time. The resident had a history of elopement, and staff were directed to monitor the resident's whereabouts and provide supervised opportunities to be outdoors when appropriate.

Facility documentation indicated in the days leading up to the incident, Resident #1's vital signs were being monitored due to the resident having increased drowsiness; the vital signs obtained were low but within normal limits.

Additional facility documentation indicated on the date of the incident, staff found Resident #1 very drowsy, noting that she could not keep her eyes open or speak well. Resident #1's vital signs which were very low, and staff reported them to the nurse. The nurse instructed staff to call 911. The resident did not wish to go to the hospital, but the resident's guardian gave permission to transport the resident to the hospital for an evaluation.

While at the hospital, Resident #1 informed her guardian that she had been smoking Resident #2'S marijuana vape-inhaler and requested to have her own vape-inhaler to use.

Resident #1 spent three days in the hospital before she returned to the facility with an order to decrease her Clonazepam prescription. A facility documented team meeting note indicated the facility would encourage Resident #1 and Resident #2 to meet in community areas instead of in their rooms to provide increased supervision.

During an interview, facility administrative staff stated Resident #1 would ask Resident #2 to pick-up items from the store with her money. Facility administrative staff stated Resident #2 was independent in going into the community after informing staff of his whereabouts.

During an interview, unlicensed staff stated Resident #1 could occasionally have dizziness after taking her Methadone. Unlicensed staff stated they found Resident #1 laying on her bed the day of the incident, barely conscious. While calling 911, the unlicensed staff had to keep Resident #1 awake. Initially, the resident refused to be transported to the hospital and recalled ambulance personnel tried to convince her to go. The unlicensed staff stated both Resident #1 and Resident #2 smoke outside together and sometimes they share a vape-inhaler.

During an interview, Resident #2'S case manager stated the resident received bus passes for transport and was allowed to come and go from the facility with the understanding that he informs facility staff of his whereabouts.

During an interview, Resident #1's case manager stated Resident #1 was free to go into the community but did not do so due to mobility issues and the use of a walker.

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-one interviewed: Declined to interview.
Vulnerable Adult-two interviewed: Declined to interview.

Family/Responsible Party interviewed Resident #1: Yes.
Family/Responsible Party interviewed Resident #2: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility staff assessed and monitored the resident's condition. When staff observed a change in condition the resident was sent to the emergency room. Following the incident, staff increased supervision of the residents.

Action taken by the Minnesota Department of Health:
No further action 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
	37322	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES LLC	6600 CENTRAL AVENUE NE FRIDLEY, MN 55432

(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 February 4, 2025 through February 14, 2025, the Minnesota Department of Health conducted a complaint investigation #HL373221378C/#HL373226903M. No correction orders are issued.	0 000		