Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL008247405M
Compliance #: HL008243969C

Date Concluded: March 12, 2024

Name, Address, and County of Licensee Investigated:
Revere Home
300 Main Street
Revere, MN 56166
Redwood County

Facility Type: Boarding Care Home

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected a resident when the AP sold the resident methamphetamine.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP sold methamphetamine and marijuana to resident #2 on two separate occasions. Resident #2 used the methamphetamine and marijuana with resident #1 while they resided at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of medical records, personnel records, internal investigation, and facility policies. The investigator also reviewed the police report.

Resident #1 and resident #2 resided at a board and care home.

Resident #1's diagnoses included schizoaffective disorder, bipolar disorder, and depression. Resident #1 received services for drug addiction monitoring and medication management. Resident #1 was alert and oriented.

Resident #2's diagnoses included bipolar disorder, stimulant use disorder, and anxiety. Resident #2 received services for drug addiction monitoring and medication management. Resident #2 was alert and oriented.

During an interview, a member of management said both resident #1 and resident #2 reported they used methamphetamine drugs brought in by the AP. She said resident #2 reported the AP brought him the drugs and resident #1 paid for the drugs. She said both residents were tested for drugs and both residents tested positive for methamphetamine. She said the AP never answered her phone call but responded to a text message and denied he brought drugs into the facility. The management staff member told the AP not to return to work until an investigation was completed and the AP responded he was never coming back. She said the AP contacted resident #2 after the incident. The AP called resident #2 a liar and was upset resident #2 reported the incident.

During an interview, an unlicensed personnel (ULP) said she completed the AP's initial training as a cook. She said the AP was "high energy." She asked the AP about his high energy level and the AP told her he had attention deficit hyperactive disorder. After she heard about the incident, she thought the AP's behavior was caused by drug use. She said resident #1 and resident #2 never accused any other staff members of selling or bringing drugs into the facility. The ULP believed the AP brought resident #1 and resident #2 drugs.

During an interview, the AP said he never sold or brought in drugs to the facility. He did not know why the residents would report he sold them drugs. The residents talked about drugs and ask him to bring drugs to them. The AP said he never documented these conversations.

During an interview, resident #1 said the AP bragged about using drugs. He said the AP and resident #2 would hang out in the AP's car. Resident #1 said he gave money to resident #2 for methamphetamine. Resident #1 said they purchased methamphetamine from the AP, and he saw the AP give it to resident #2. Resident #1 said they purchased methamphetamine from the AP on two occasions.

During an interview, resident #2 said he purchased methamphetamine on two occasions from the AP, who was a staff member at the facility. He said he snorted the methamphetamine with resident #1. He said the AP texted him after the incident. The AP was upset because "I got him fired."

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

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, both resident #1 and resident #2.
Family/Responsible Party interviewed: Not Applicable. Resident #1 and resident #2 were their own persons.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, and the AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Redwood County Attorney
Revere City Attorney
Revere Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00824	A. BUILDING: _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVERE HOME	300 SOUTH MAIN REVERE, MN 56166

(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
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 16, 2024, the Minnesota Department of Health initiated an investigation of complaint HL008247405M/HL008243969C. The following correction order is issued. The following correction order is issued/orders	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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3 000	Continued From page 1 are issued for HL008247405M/HL008243969C, tag identification 1850.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
31850	MN Rule 144.651 Subd. 14 Patients & Residents of HCF Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints,	31850		

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31850	Continued From page 2 except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	31850	No plan of correction is required for this tag.	