Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H72276462M
Compliance #: H72272365C

Date Concluded: December 2, 2025

Name, Address, and County of Licensee Investigated:
Senior Friend Home Care
1111 Cloquet Avenue Suite 3
Cloquet, MN 55720
Carlton County

Facility Type: Home Health Agency (HHA)

Evaluator's Name: Willette Shafer, RN
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 alleged perpetrator (AP) neglected the client when the AP failed to notify the client's family or medical provider about a recent change in condition and the resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP was notified about the client's recent illness and failed to notify a family member, the family member was with the client the day before the resident died. The family member was aware the client was not feeling well in the days prior. The client reported feeling better the day before she died and was even out of her apartment visiting with other residents. The client lived independently, was cognitively intact, and was her own decision maker and managed her own healthcare needs. The client received weekly home-making services and one to two times a week home health aide services for bathing and foot care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the client record, death record, pharmacy records, facility internal investigation, staff schedules, and related facility policy and procedures.

The client lived in her apartment and received scheduled visits from a home health agency. The client's diagnoses included a history of pulmonary embolism, hypertension, diabetes, and chronic obstructive pulmonary disease. The client's service plan included assistance with weekly homemaker services for housekeeping and laundry, one to two times per week home health aide services for bathing and foot care, and skilled nursing supervisory visit one to three times per month with every 60-day nursing reviews. The client's most recent assessment indicated she was oriented, and her cognition was intact.

A progress note written by unlicensed personnel (ULP)-1 indicated the client bed was "soaked in urine" and the client was "not feeling well." ULP-2 contacted the AP, a nurse.

A text message sent by ULP-2 to the AP indicated the client reported discomfort while urinating, possible low body temperature, and she looked tired. The AP asked what the client's last name was, if she had family, and if she was willing to go in for a urine test. ULP-2 responded the client had a family member and the client said "okay."

The facility's internal investigation indicated ULP-2 notified the AP about the clients change of condition via text message. The AP asked ULP-2 if the client had family, if she contacted them and if the client would want to see a provider. ULP-2 responded the client had a brother-in-law and "Yes, she will go." The AP reviewed the client's medical record, and no family member was identified in the client's record. The AP never contacted anyone. Four days later, ULP-1 visited the client and observed her condition had worsened. ULP-1 contacted the client's family member via phone. The family member told ULP-1 another family member would check on the client. The client died the following day.

The client's death record indicated her cause of death was cardiac arrest related to coronary artery disease, hypertension, and diabetes.

During an interview, ULP-1 stated she provided housekeeping and laundry services to the client once a week. One day she noticed the client's bed was soaked with urine which was unusual for the client. The client reported she was urinating more frequently and the urine observed in the toilet was dark. ULP-2 who was also present during this interaction, messaged the AP via text and reported the concerns. The AP responded she would notify family. A few days later, ULP-1 observed the client during an unscheduled visit. ULP-1 said the client was warm and looked weak. ULP-1 called the client's family member and reported her observation. The next day the client passed away.

During an interview, ULP-2 said she provide bathing services and foot checks to the client twice a week. During a scheduled visit she and ULP-1 noticed the client's urine appeared darker and her bed was wet. She texted the AP and reported her observation. The AP asked about the client's family and said she would contact them. When ULP-2 arrived for her next scheduled visit a few days later, the ambulance was there, and the client had died.

During an interview, the AP who was also a nurse said she was recently hired for a management position, but a nurse resigned so the AP took over her clients until another nurse was hired. The client was not assigned to the AP, and she was unfamiliar with the client. When ULP-2 texted her with concerns about the client the AP was in an appointment with another client. After the appointment was done, she attempted to contact the client's family, but no family or emergency contact was identified in the client's record. She called nurse-2 and reported the information but never followed up with family or the client.

During an interview, nurse-2, who is also a member of management said she first heard about the incident after the client died. She conducted the internal investigation and determined ULP-2 reported the client's change of condition to the AP who failed to contact the client's family. She said the client was independent and cognitively intact. The client did not receive skilled nursing services. The client managed her own medications brought in by family. The client was out of three medications for at least three days before she died which may have contributed to her death.

During an interview, the family member said the client lived independently in her own apartment and she was "very sharp." He visited the client the day before she died. He said the client was in the lobby visiting with friends during the day. The client reported feeling better than she had the last few days and denied pain. The client had a close friend who lived in the same apartment building and visited with the client daily. He reported the client's friend was also with the client the day before she died. He or the client's friend would have brought the client to the doctor if she wanted to be seen but the client said she was feeling better.

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 interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and updated policies and procedures.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR FRIEND HOME CARE	**1111 Cloquet Ave, Ste. #3 , Cloquet, Minnesota, 55720**

(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) COMPLETION DATE
00000	Integrated License (HCBS) Initial Comments The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H72276462M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	00000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE