Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report : HL203869422M
Compliance : HL203863503C

Date Concluded: July 6, 2026

Name, Address, and County of Licensee Investigated:
Sacred Heart Assisted Living
1202 12th St SW
Austin, MN 55912
Mower County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when the care plan was not followed, and the resident showered without standby assistance. The resident fell in the shower and was hospitalized with hypothermia.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. A caregiver offered to assist the resident after the evening mealtime was completed but the resident declined and chose to shower without staff present. At some point during the shower, the resident slid to the floor and became incoherent.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, death record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed supervision of residents and staff interactions and reviewed their care plans.

The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder and macular degeneration. The resident's service plan included assistance with medications, applying and removing compression socks, and safety checks. The resident used a wheelchair independently for mobility.

The resident's individual service plan assessment indicated the resident had required increased assistance with light physical activity, for example assistance getting up from the chair and stand by assistance with showers, where prior the resident was completely independent.

One day the resident summoned staff assistance removing her compression stockings and the topic of her shower was discussed. The caregiver told the resident would be available to assist after the evening meal was completed, however the resident said she wanted her shower a bit earlier and would do it on her own. Later, staff returned with the resident's medications, but the bathroom door was shut, and they heard the water at the sink running. There was nothing to indicate concern at that time, so staff left to return later. When staff returned, the carpet outside the bathroom was soaked with water and the resident was found on the floor in the shower area, partially responsive. The resident was transferred to the hospital.

The resident's hospital notes indicated the resident was brought to the emergency room with a thready pulse and a temperature of 25.9 degrees Celsius (78.6 degrees Fahrenheit). She was warmed, given airway management and became more responsive.

During interview, a caregiver stated the resident asked about her shower. The caregiver explained to her she could help after supper. The resident did not give any indication she was going to do it on her own. The caregiver stated the resident liked to go to bed early and thought was why she did not wait for assistance.

During interview, the manager stated she believed the resident wanted an earlier shower because she did not want to go to bed with wet hair. The manager stated although she was care planned as a standby shower assist, the resident could make the decision to shower on her own at any time as she was considered independent in her apartment.

During interview, the nurse stated the resident could have anxious episodes that could come on without warning. The nurse also stated that the resident was capable of making her own decisions.

During interview, a family member stated they did not think the resident actually fell as she had no injuries or bruises. The family member stated she may have become anxious, which was common for her, and attempted to shut off the water and slid to the floor with the cold water running on her causing hypothermia. Later, the resident admitted to family she did not want to wait for staff assistance and took it upon herself to shower independently. The resident did not fully recover and passed away several weeks later.

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, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility reviewed care plans along with current practices. Staff were instructed to call the nurse any time a resident’s desired activity differs from the care plan.

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
	20386	A. BUILDING: _____ B. WING _____	C 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART ASSISTED LVG APTS	1202 12TH ST SW AUSTIN, MN 55912

(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 May 14, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL203863503C/#HL203869422M. No correction orders are issued.	0 000		