*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL216237402M
**Compliance #:** HL216232720C

**Date Concluded:** March 28, 2025

**Name, Address, and County of Licensee Investigated:**
Heathers Manor
3000 Douglas Drive North
Crystal, MN 55422
Hennepin County

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

**Evaluator's Name:**
Maerin Renee, RN, Special Investigator

**Finding:** Substantiated, facility 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 the resident when a call light was activated early in the morning and the AP did not provide assistance. The resident later died.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure staff were able to respond to the residents' requests for assistance, and failed to ensure staff were reporting off to the next shift and ensuring there was another staff in the building to provide care to the residents. The resident's roommate activated both his and the residents call pendants when he noticed the resident's health status was declining. The staff failed to respond to the residents' roommates call pendant for over 4 hours. When the AP received a phone call from the resident's family to check on the resident, the resident was deceased. The AP was unaware of the residents' roommates call pendent being activated, and was not aware the staff member who was assigned to provide cares for the resident and his roommate did not show up for his shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident records, death record, the facility internal investigation, facility incident reports, personnel files, staff schedules, pendant reports, timecard reports, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included atrial fibrillation, high blood pressure, aortic valve stenosis, and mild cognitive impairment. The resident's services included help with activities of daily living, medication management, meals, housekeeping, and laundry.  The resident's assessment indicated the resident displayed mild memory loss and forgetfulness.

The facility internal investigation indicated the AP called a nursing supervisor around 6:00 a.m. to inform him the resident had passed away. The AP also said she just found out she was the only staff member in the building on the overnight shift because her co-worker did not show up for his shift. The call pendant log indicated the resident's roommate activated the resident's pendant and his own pendant around 2:00 a.m. The resident's pendant was reset after several seconds, while the roommate's pendant was activated for over four hours. The AP said she thought the resident's pendant had been answered by her coworker.

The police report indicated officers were dispatched to the facility at 6:24 a.m. for reports of a deceased resident. Upon arrival, the resident was found lying in bed with no obvious injuries. The report indicated the resident was not breathing and had no pulse.  However, the resident's skin condition was not consistent with someone who had been deceased for a long period of time, so law enforcement started cardiopulmonary resuscitation (CPR) until emergency services arrived. Emergency services continued resuscitation efforts for approximately 30 minutes but were not successful. The report indicated the resident's roommate stated he called the nurse line at the facility around 3:00 a.m. but no one answered, and also pushed his call pendent but staff never came.

The nursing supervisor stated the AP said she did not respond to the call light because she saw the resident's pendant was reset and assumed her coworker responded to it. The AP never saw the roommate's pendant was activated because she did not hear the chime alert. The AP checked on the resident after the resident's family member called and the resident was found deceased.

The AP's coworker stated he did not realize he was scheduled to work that night, and stated his coworker would not know if he was working or not because staff did not see each other throughout the shift.

The pendant summary log indicated the resident's pendant alarm was activated and reset eight seconds later. This was consistent with the button being held down for 8 seconds or more

resulting in the activation and immediate resetting of the pendant. The residents' roommates pendent was activated requesting assistance for over 4 hours.

When interviewed, the AP said the coworker scheduled to work the overnight shift with her frequently did not come in for work or would come in late. The AP said she heard the resident's roommates pendant chime, and the residents pendent alarm went off for approximately 8 seconds and then had been reset, so the AP assumed her coworker had responded to both residents' alarms. The AP said she did not log back into her tablet for the rest of the shift, so she was not aware the residents' roommates pendent alarm had not been responded to. The AP said she received a phone call at approximately 6:00 a.m. from the resident's family member and that is when she realized she had been working alone the entire night. The AP checked on the resident, found him deceased, and called 911.

The resident's death record indicated the cause of death was atrial fibrillation due to hypertension and aortic stenosis. The manner of death was documented as natural.

When interviewed, an administrator stated staff were expected to communicate and coordinate with each other on their shifts and cover each other on breaks. Staff were trained to contact an individual if they did not show up, and the nursing supervisor or nurse on call for staffing assistance. On that night, the team failed to do so. The AP did not realize she was working alone on the overnight until the resident's family member called toward the end of her shift. The resident's family member called the nurse line around 6:00 a.m. because the resident's roommate had not been able to find staff to help the resident and called the resident's family member. The AP checked her tablet and saw the roommate's pendant had been activated for over four hours. The AP stated she did not take breaks and normally did not see her coworker during the night shift as they worked on different floors. The administrator stated staff were expected to check their tablets 'frequently' to monitor and respond to resident pendent alarms. In addition, when the prior shift leaves the facility, they should be reporting off to the next staff member replacing them.

Review of time sheets indicated the AP, and her coworker worked together seven times in the timeframe reviewed. The coworker punched in late on two occasions, 34 minutes late once and 20 minutes late once. He worked as scheduled for the remaining shifts.

When interviewed, the resident's family member stated she received a voicemail from the resident's roommate at around 2:00 a.m. but did not hear the voicemail until around 6:00 a.m. The family member stated she called the facility's nurse line, and the AP answered. The family member told the AP the resident's roommate had called for assistance and staff were not responding. The family member stated after she spoke to the residents roommate he stated no one answered his pendant so he walked through the facility looking for someone to help the resident but found no one so he called the family member looking for help.

In conclusion, the Minnesota Department of Health determined neglect was 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**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
The facility provided refresher training for staff regarding the pendant call system and shift change procedures. The pendant system was updated so the after-hours nurse phone and the nursing supervisor phone would be alerted when a pendant went off for 30 minutes or more. Also, requested chiming alert system continue to chime until pendant is reset.

**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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21623 | A. BUILDING: _____ B. WING _____ | C 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEATHERS MANOR | 3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422 |

| (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>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 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>#HL216232720C/#HL216237402M<br><br>On February 7, 2025, 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 55 residents receiving services under the provider's Assisted Living license.<br><br>The following correction order is issued for #HL216232720C/#HL216237402M, tag identification 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 | 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.<br><br>Please refer to the public maltreatment report for details. | 02360 | | |