

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL254558286M  
**Compliance #:** HL254555465C

**Date Concluded:** January 4, 2024

**Name, Address, and County of Licensee**

**Investigated:**

Heritage Haven Assisted Living  
3040 Morris Thomas Rd.  
Duluth, MN 55811  
St. Louis County

**Facility Type:** Assisted Living Facility with  
Dementia Care (ALFDC)

**Evaluator's Name:**

Jana Wegener, 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 resident was neglected when the facility failed to assess the resident for injuries after a fall when the resident complained of pain. The resident died eight days later.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The residents plan of care was being followed at the time of the fall and the resident was assessed and had no apparent injuries when the nurse assessed the resident following the fall. Four days later, the resident was admitted to the hospital with back pain, elevated blood pressure, and increased confusion. The resident was discharged back to the facility the following day on end-of-life cares. The resident died 8 days later due to kidney disease.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of resident records including assessments, care plan, service plan,

service delivery of care record, fall incident reports/post fall assessment, hospital after visit summaries (AVS), progress notes, staff communication, medication administration records, provider communication/orders, and facility policies and procedures. Also, the investigator observed resident's and staff interactions at the facility.

The resident resided in an assisted living dementia care facility with diagnoses including end stage renal disease, type II Diabetes Meletus, dementia, and hypertension.

The resident's assessment and care plan identified she was at a high risk for falls related to a history of falls, below the knee amputation, visual impairment, poor decision-making ability, and history of self-transferring. The assessment and care plan included various interventions to reduce the occurrence of falls.

An incident report indicated one day the resident had an unwitnessed fall. The resident stated she was looking at things on her bookshelf and fell out of her chair. The staff immediately reported the incident to the nurse. The nurse assessed the resident had no change in range of motion or mobility after the fall. The incident report indicated the resident had a bruise on her left eyebrow, and neurologic assessments were completed, with no concerns identified.

The resident's progress notes indicated after the fall the resident had full range of motion but reported pain when moving her left leg. A follow up progress note indicated when the nurse assessed the resident for injuries, the resident had full range of motion and slight tenderness in the opposite leg. When the nurse assessed the resident after the incident there was no indication the resident had pain in her left leg.

A faxed communication to the resident's provider the following day indicated the facility reported the resident had hip and back pain, with orders for a transdermal lidocaine patch received.

Three days later a hospital note indicated the resident was admitted to the hospital with back pain, hypertension, and increased confusion.

The resident record indicated while hospitalized, the resident was admitted to hospice for end-of-life care related to end stage renal disease, and hemodialysis was discontinued. The resident was readmitted to the facility the following day. The resident died at the facility 8 days later.

The resident's record of death indicated the resident died of natural causes related to end stage renal disease.

When interviewed facility staff stated the resident was assessed for injuries after the fall occurred and no injuries were noted.

When interviewed the resident's family member stated she had no concerns with actions taken by the facility to help prevent the resident's falls, or the care and services provided. The family member stated the resident was assessed for injuries after the fall occurred, and the resident's hospice admission and subsequent death were not related to the fall that occurred at the facility.

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:** N/A.

**Action taken by facility:**

No action taken.

**Action taken by the Minnesota Department of Health:**

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>25455</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HAVEN INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3042 MORRIS THOMAS ROAD DULUTH, MN 55811</b>
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(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	<p><b>Initial Comments</b></p> <p>On December 13, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL254558286M/#HL254555465C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_