Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294563823M
Compliance #: HL294567447C

Date Concluded: August 4, 2025

Name, Address, and County of Licensee Investigated:
Keystone Bluffs Assisted Living
2528 Trinity Road
Duluth, MN, 55811
Saint Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 facility neglected the resident when staff failed to follow the resident's plan of care. The resident was found deceased on the floor next to his bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although unlicensed personnel, the alleged perpetrator (AP) failed to document services provided to the resident during the overnight shift prior to the resident being found deceased, there was not a preponderance of evidence to support that failure caused the resident's death. At the time, the resident was on hospice services and at the end of his life. The resident's cause of death was related to heart conditions and the manner of death was natural.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. Attempts to reach the AP including a subpoena were unsuccessful. The investigator contacted hospice services. The investigation included review of

the resident records, death records, facility incident report, hospice records, a personnel file, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed the facility.

The resident resided in an assisted living facility. The resident's diagnoses included chronic heart failure with preserved ejection fraction (heart muscle becomes stiff) and atherosclerotic (plaque buildup in arteries) and hypertensive cardiovascular disease (caused by long term high blood pressure.) The resident's service plan included assistance with every two-hour incontinence management and repositioning services. The resident was receiving hospice services for end-of-life care and comfort care.

Hospice records indicated prior to the resident's death; hospice increased the resident's visits to daily for end-of-life care.

A facility incident report indicated one day during the morning shift; unlicensed personnel entered the resident's room to conduct every two-hour checks. The unlicensed personnel found the resident on the floor next to his bed lying on his left side with no signs of life. Licensed staff and hospice were called, and multiple unlicensed staff lifted the resident back into bed.

The resident's service delivery records did not include documentation the unlicensed personnel assigned to the resident during the night shift provided care for the resident at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. prior to the resident being found deceased on the floor.

During investigative interviews, multiple overnight unlicensed personnel stated they had cared for the resident within a couple days of his death. During their checks, the resident slept, and at times the resident moved around when he slept and occasionally awoke during the brief changes. At times, staff found the resident with his feet or leg off the bed. When that occurred, staff repositioned the resident's legs and placed his feet back into bed.

During an interview, the unlicensed personnel that worked the same overnight shift prior to the resident's death but not assigned to care for the resident stated, nothing stood out as being abnormal going on during the shift.

During an interview, another unlicensed personnel stated the resident was on hospice services, was bedridden, and required every two-hour checks. The unlicensed personnel stated that day she started her shift at 6:00 a.m. and checked on the resident around 8:00 a.m. When entering the resident's room, the resident was lying on the floor next to his bed. The unlicensed personnel stated the resident was cold to touch and deceased. The unlicensed staff stated multiple unlicensed staff assisted the resident off the floor back into bed. The unlicensed personnel stated at the change of shift; she spoke directly to the AP who did not report any changes regarding the resident.

During an interview, another unlicensed personnel stated she assisted with lifting the resident off the floor. The unlicensed personnel stated she contacted the facility on-call nurse as well as hospice services. The unlicensed personnel stated when she cared for the resident a couple days prior, the resident was bedridden, not getting up, and was not talking much.

During an interview, a facility nurse stated she received a call from unlicensed personnel that the resident was found deceased on the floor next to his bed. Prior to the resident's death, the resident was not doing well, had been in bed, was in a health decline, and was at the end of his life. The resident had terminal restlessness and received medication for comfort.

During an interview, a contracted agency nurse stated when she arrived at the facility she provided a complete bed bath and did not notice any signs of obvious injury, bumps, or anything concerning or abnormal with the resident. The agency nurse stated prior to the resident's death; the resident had transitioned which was the first phase of the dying process. The agency nurse stated during the transition phase, the resident had increased sleepiness, confusion, restlessness, hallucinations, not eating, taking only sips of fluids, and had a general decline in normal functioning status.

During an interview, another contracted agency nurse stated the resident had a steady decline with a change in mentation, was forgetful, and confused. The contracted nurse stated during that time, the resident also had anxiety and had made attempts to crawl out of bed or have his feet hanging out of the bed. The agency nurse stated the resident had a history of falls and in order to keep the resident occupied, the resident's bed was moved to the living room near his television where he could watch baseball which the resident enjoyed.

During an interview, another facility nurse stated they attempted to contact the AP however; attempts to reach the AP were unsuccessful. The nurse stated they were unable to determine when the resident was last checked on or how the resident ended up on the floor. There was no history of concerns with the AP not providing care or services to residents. The nurse stated all staff were re-educated on the expectation of documenting services provided to residents.

The resident's death records indicated the resident's cause of death was chronic health failure with preserved ejection fraction and atherosclerotic and hypertensive cardiovascular disease. Manner of death was natural.

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: No. Attempts to reach the AP including a subpoena were unsuccessful.

Action taken by facility:
Leadership reeducated staff on expectations of documenting services provided and said staff documentation has since improved. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:

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
	29456	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE BLUFFS ASSISTED LIVING	2528 TRINITY ROAD DULUTH, MN 55811

(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 July 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL294567447C/#HL294563823M. No correction orders are issued.	0 000		