Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304958642M
Compliance #: HL304951680C

Date Concluded: March 19, 2026

Name, Address, and County of Licensee Investigated:
Vitacare Living Spirit Valley
102 North 58th Avenue West
Duluth, MN 55807
St. Louis County

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

Evaluator's Name: Deb Schillinger RN BSN
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 interventions were not followed, and the resident fell.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had recurrent falls, the facility staff was following the plan of care. After the falls, a meeting was held, including family members and the medical provider, where the service plan was reviewed and updated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and

procedures. Also, the investigator observed resident and facility staff interactions during an onsite visit.

The resident resided in an assisted living memory care facility. The resident's diagnoses included dementia and anxiety. The resident's service plan included assistance with medication management and administration and safety checks. The resident's assessment indicated that the resident had cognitive impairment, was able to walk independently and was at risk to wander.

The resident's medical records indicated that the resident had two falls in a 2-week period. Following each fall, the unlicensed caregiver immediately updated the nurse on call, who updated family members and the medical provider. Subsequently, the nurse completed a post-fall review for each fall then in coordination with family members and medical provider, modified interventions to prevent future falls.

Incident report #1
After an unwitnessed fall, the resident was able to get up and walk independently to notify an unlicensed caregiver. The resident was found to have a bump to her left eyebrow area and abrasions to right shin and knee area. The unlicensed caregiver notified the nurse on call, who then notified the family members and medical provider. Family members came to the facility and made the decision not to send the resident out for evaluation.

The resident's medical record indicated two days after the fall family members took the resident out for an evaluation, where the resident was treated for a possible infection.

Incident #2
The resident was found on floor of restroom, after an unwitnessed fall where she stated she slipped. The unlicensed caregiver assisted the resident off the floor and notified the nurse. The unlicensed caregiver notified the nurse on call, who then notified the family members and medical provider. The family members requested safety checks be increased to every 30 minutes through the night.

Three days later, a meeting was held and included the family members and the medical provider, to determine if the resident's needs were greater than the care the facility could provide. Medications were adjusted and new interventions added to service plan.

During an interview, a nurse reported that the resident had two unwitnessed falls, and the nurse was not present in facility during either unwitnessed fall. The resident had a camera in her room, but neither fall was captured on camera. After the second fall, hourly safety checks were initiated, and new interventions to redirect the resident if awakened during the night. The nurse stated a low bed was ordered and the medical provider was working with the insurance provider to obtain. The nurse stated the resident had a risk of wandering and a history of exit seeking in the past. The resident was using a wanderguard for safety, however this has been

removed per family request. The nurse stated she felt the resident needed a higher level of care than the facility provided.
During an interview, a nurse manager stated after a care coordination meeting with family members and medical providers, changes were made to medications, and new interventions were added to service plan. The wanderguard was removed according to the family members' because they felt it was emotionally distressing to the resident. The nurse manager reported that the resident had no additional falls and exit seeking behaviors improved. The nurse manager reported training was scheduled with caregivers to assure the service plan updates were communicated.

During an interview, family members stated that after the falls, medication changes were made, according to their request and the resident had not experienced additional falls and behaviors have decreased.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Added interventions, worked with family members and medical provider changing medications and monitoring behaviors for a positive effect for resident.

Action taken by the Minnesota Department of Health:
No further action is taken 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
	30495	A. BUILDING: _____ B. WING _____	C 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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 January 28, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL304951680C/#HL304958642M. No correction orders are issued.	0 000		