Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305008184M
Compliance #: HL305005244C

Date Concluded: December 27, 2023

Name, Address, and County of Licensee Investigated:

Evensong Manor
6264 Yukon Avenue North
Brooklyn Park, MN, 55428
Hennepin 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 Allegations:
Allegation #1: The facility neglected the resident when the facility failed to monitor the resident's blood sugars or provide enough food to eat.

Allegation #2: The facility neglect occurred when the facility did not check on the resident over a period of time and the resident was found deceased.

Investigative Findings and Conclusion:
Allegation #1 The Minnesota Department of Health determined neglect was not substantiated. Although the resident's glucose checks were not consistently recorded, the facility nurse coordinated with the resident's medical provider appropriately regarding diabetes management. At times, the resident preferred food choices other than that offered by the facility's meal choices.

Allegation #2: The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident had died while lying in bed, it was also true her to sleep later in

the day and, if she was not feeling well, to stay in bed all day. Brief checks performed by two staff members confirmed she was lying in bed and may not have realized she had died; the evidence does not indicate this contributed to the resident's death.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement for the police report and 911 audio as well as the medical examiner for the autopsy and cause of death information. The investigation included review of facility incident reports, resident deaths, and facility policies. Also, the investigator observed made a visit to the facility and observed staff interactions with residents, medication pass and toured the building for cleanliness. Mealtime was observed as well as meal menus and resident's access to food. Other residents were interviewed regarding the care they received, and whether they had any medication issues or concerns regarding access to food and meals.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and diabetes. The resident's service plan included assistance with medication management, blood glucose monitoring, bathing, housekeeping, laundry, meals and safety checks. The resident's assessment indicated she was oriented, able to make her needs known but had demonstrated poor decision making.

The resident's medical record indicated her medical provider followed her for health issues and required recent medication changes. Nursing progress notes indicated the resident complained of tiredness and would nap frequently. Although review of the resident's medication records indicated medication administration lacked a consistent method of documentation, nothing indicated the resident went without her ordered medications.

Review of the on-scene medical examiner note indicated the resident had fixed livor and rigor (changes that occur after a person dies) indicating she had been deceased for more than several hours.

The investigation included interviews with multiple facility staff members were interviewed. Staff stated the resident did not like to eat the homemade meals the facility prepared. Staff members stated they assisted the resident with blood glucose and documented the results. The nurse stated that the resident's blood glucose results were monitored, and the resident chose not to adhere to a diabetic type of diet.

Staff interviews indicated the resident often stayed up during the night and slept late in the day so, on the day of the resident's death, staff were not too concerned that she stayed in bed into the afternoon. The staff member who was working when the resident was found unresponsive stated the resident had not felt well the day before but was able to take her medications. He stated when he last checked on her, she seemed to be asleep.

Interview with a facility resident indicated that in the days prior to the resident's death, the resident had not been feeling well but did not want to go to the doctor.

A summary of the resident's autopsy report indicated the resident had evidence of heart, pancreas, liver, and kidney disease. The resident's death certificate indicated the cause of death was hypertensive and atherosclerotic heart disease and the 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: No, the family member did not return requests for interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
No action 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
	30500	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENSONG MANOR	6264 YUKON AVENUE NORTH BROOKLYN PARK, MN 55428

(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 September 26, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL305005244C/#HL305008184M. No correction orders are issued.	0 000		