Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306968104M
Compliance #: HL306964420C

Date Concluded: March 31, 2025

Name, Address, and County of Licensee Investigated:
Inver Grove Heights WP LLC
9056 Buchanan Trail
Inver Grove Heights, MN 55077
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility and individual 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 perpetrators (AP)-1 and AP-2 neglected the resident when they failed to complete safety checks per the resident's care plan during the night shift. The resident fell on the floor and was not found for an extended period. The resident later died at the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and AP-1 were responsible for the maltreatment. The facility failed to ensure multiple staff were competent with policies and procedures including rounds at shift change, service plan development, and providing resident cares. AP-1 failed to provide safety checks per the resident's care plan which resulted in the resident lying on the floor in her urine for an extended period. The resident was diagnosed with hypothermia and other painful conditions as a result from lying on the floor for an extended period. The resident later died at the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident report, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff completing safety checks and resident cares at the facility. AP-2 was not responsible for maltreatment. AP-2 worked the same night of the incident, but was not assigned to provide care to the resident.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes with kidney complications, heart failure, muscle weakness, and history of a mini stroke. The resident's service plan included assistance with fall interventions including safety checks every two hours, assist of two with full body lift for all transfers, assist of one to turn and reposition, and incontinence cares. The resident was recently admitted from a transitional care unit. Her initial assessment indicated she was at an increased risk for falls.

The ambulance report indicated the resident was lying face down on the floor. She had mottled (purple spots or netted pattern often associated with poor blood flow or end of life) and cyanotic (blue) skin on her legs. Staff reported she was last seen at 6:00 a.m. in bed and later found in a "downward dog" position on the floor. She awakened when spoken to but failed to respond appropriately. The resident's legs, fingers, and ears were cold and pale. The resident had also vomited. Her blood sugar was high and blood pressure very low. Her left leg appeared to have compartment syndrome (painful and dangerous condition caused by buildup from internal bleeding and swollen tissue) from her foot pinned under her body for an extended amount of time. Her leg and foot were swollen with imprints of the floor in her skin. She was transported as emergent to the hospital's emergency department.

The resident's hospital record indicated she was diagnosed with traumatic rhabdomyolysis (a serious medical condition that occurs when skeletal muscles are damaged, leading to the release of muscle proteins and other substances into the blood stream) usually caused by trauma, prolonged compression on muscles, and compartment syndrome. The resident was found on the floor in her urine and her vital signs indicated she had hypothermia. Staff reported the resident was observed in the morning, but the resident's record indicated she was last observed last night. It appeared the resident had been on the floor for an extended period of time. The resident died at the hospital later that evening.

The internal investigation indicated the resident was found on the floor next to her bed shortly after the day shift arrived. When the day shift arrived, AP-1 failed to complete rounds with the day shift staff member. AP-1 reported he last checked on the resident between 1:00 a.m. and 2:00 a.m. AP-1 was unaware the resident received safety checks every two hours and he reported the service plan indicated she received safety checks once per shift. AP-2 reported she was assigned to administer medications that night and no medications were administered to the resident. AP-1 never asked AP-2 to assist with the resident's cares. The resident's service plan indicated the resident received safety checks every shift versus every two hours and the

nurse was educated on entering services into the computer correctly and ensuring services are implemented as agreed upon.

The resident's service plan, signed the date of admission, indicated the resident received safety checks every two hours on all shifts. The service plan indicated the resident transferred using a full body lift but also was a 1-2 person assist staff. The service plan also contradicted itself as it indicated the resident received incontinence care (check and change) and indicated she was assisted to the toilet.

The resident's vulnerability assessment indicated she received safety checks every two hours.

The resident's progress notes indicated safety checks every two hours were not completed through the night and the resident's bed was in the high position at the time of the fall.

The service delivery record signed by AP-1 indicated AP-1 reviewed and understood the services and level of care the resident received. AP-1 also initialed he completed all services for the resident during the night shift including safety checks every two hours.

The service delivery record indicated the resident transferred using a Hoyer lift with assist of two staff, but it also indicated the resident was a 1-2 person transfer with a transfer belt. The service delivery record indicated the resident received assistance with incontinence care, but it also indicated she received assistance to the toilet. Even though the services to provide safety checks was documented once per shift, the direction indicated the resident required she needed safety checks every two hours.

During an interview, a family member said the resident received safety checks every two hours on all three shifts. She said during the initial facility tour, a member of management told her safety check were completed at a minimum of every three hours. She was concerned that every three hours was not frequent enough but the member of management reassured her that staff check on the residents more frequently than every three hours as they are often in the resident's apartments providing other services.

During an interview, AP-2 said she was assigned to administer medications the night of the incident. She said the resident had no medications scheduled during the night. AP-1 was assigned to provide resident cares and compete safety checks every two hours. AP-1 never asked AP-2 for assistance with the resident. AP-2 said she never saw the resident on the night shift but was available to assist if needed. She said the caregivers are assigned to complete rounds together at shift change. The caregivers must visually check each resident while the staff assigned to administer medications count medications together. She said AP-1 and the caregiver who worked the day shift never completed rounds together.

During an interview, unlicensed personnel (ULP)-1 said she was assigned to administer medications to the resident on the day shift. When she entered the resident's apartment

around 7:30 a.m., she observed the resident face down on the floor next to her bed. ULP-1 ran to call emergency services. She said it appeared the resident tried to get out of bed and fell. She had a scrape on her leg and was taken to the hospital. She was unsure when the resident was last checked on. She said most resident's received safety checks every two hours, but this resident only received safety checks once per shift.

During an interview, a member of management said she completed the internal investigation. She indicated the resident received daily safety checks and the service delivery record indicated safety checks once per shift. When MDH investigator reviewed the inconsistences in the internal investigation and the service delivery record and service plan, she stated she was given incorrect information from members of the team during the internal investigation. The member of management said staff must complete rounds together during shift change. When asked how staff complete rounds at shift change when there is no overlap in their schedules, she said one of the staff must arrive early or stay late. She said the facility had no policy on completing rounds together at shift change rather it was a practice management put in place. She remembered a conversation with family where the family expressed concern about the frequency of safety checks. She said family was told staff often checked on the residents more frequently than every few hours as services are completed frequently.

During an interview, ULP-2 said he worked the day shift the morning of the incident. He was assigned as a caregiver but was asked to cook as the day shift cook called in. He said he was trained on both roles. He said the caregivers' complete rounds together at shift change on each resident. Since there is no overlap between shift times, one staff must stay late to complete rounds. When a new resident is admitted, all staff must read the resident's services plans before they provide services. The resident's service plan is in a binder in the nurse's station. He said services should have specific times added to alert the caregivers to provide services at specific times but when the service plan indicated one time a day (days, evenings or nights) the staff must complete the resident cares based on what the service plan indicated when reviewed.

During an interview, the nurse said she was newly hired before the incident. The resident's service plan was the first service plan she completed. The resident received safety checks every two hours and the service plan indicated every two hours. The service delivery record indicated every two hours but instead of populating a time every two hours, the service showed up once per shift. The resident also received check and change services and turn and reposition services. Services such as turn and reposition don't always indicate specific times, but staff are trained to check to see if residents need to be changed every two hours. Likewise, staff should check every two hours to see if a resident needs repositioning. She said she accidentally checked the incorrect interventions on the resident's fall assessment. The family never signed a waiver declining safety checks every two hours at night. All staff are trained on the resident's service plan when a new resident is admitted. A meeting was held twice per day for three days to educate staff members on the resident when she was admitted. The resident's service plan was placed in the service plan binder in the nurse's station and staff must review the service plan.

AP-1 never documented on services the night of the incident. She was unsure why AP-1's initials show up on the service delivery record now. She said staff only complete verbal rounds on each resident between shifts. Staff are not expected to walk through the facility together and visually observe each resident. She was unsure if the facility had a policy about staff completing rounds together. Although the resident was diagnosed with diabetes, the resident did not receive blood sugar monitoring. She acknowledged a nurse's note should have been documented regarding the resident's diabetic management plan. She acknowledged she completed the service plan incorrectly as it indicated the resident was both a full body lift and a 1–2-person transfer. She acknowledged the service plan indicated the resident used the toilet and indicated she received check and change incontinence services. She said incontinence cares are completed every two hours. AP-1 should have checked to see if the resident needed incontinence cares every two hours. The resident received turn and repositioning services. She said staff were educated to turn and reposition the resident every two hours. AP-1 should have completed repositioning with the resident every two hours.

AP-1 failed to respond for an interview.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The facility and the AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: AP-2 interviewed. AP-1 never returned call for interview request.

Action taken by facility:
The facility completed an internal investigation and re-educated all employees on multiple policies. The facility implemented multiple performance improvement plans on employees and employee audits.

Action taken by the Minnesota Department of Health:
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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Inver Grove City Attorney
Inver Grove Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30696	A. BUILDING: _____ B. WING _____	C 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WHITE PINE	9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL306964420C/HL306968104M HL306969724C/HL306966522M On March 12, 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 58 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL306964420C/HL306968104M, tag identification 2360. There are no correction orders issued for HL306969724C/HL306966522M.	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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 Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		