Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370719582M
Compliance #: HL370718921C

Date Concluded: May 9, 2025

Name, Address, and County of Licensee Investigated:
Boulder Ponds Senior Living
192 Jade Trail N.
Lake Elmo, MN 55042
Washington 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 the "I'm okay" check was not completed, and the resident was found deceased in her bed.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the "I'm okay" check was not completed as planned earlier in the day, the resident was found deceased in her bed in her nightclothes and likely passed away in her sleep. The death record indicated the cause of death was suspected cardiac arrest and her advanced directives called for do night resuscitate.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the family member. The investigation included review of the resident record, death record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between residents and facility staff during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (where the heart is unable to pump enough blood for the body's needs), type 2 diabetes and chronic kidney disease (a gradual loss of kidney function). The resident's assessment indicated the resident was independent with all cares. The resident was receiving care from a home health care agency for wound care. Her advanced directives indicated do not resuscitate.

The service plan indicated the resident agreed to one assisted living service which was a once a month wellness visit with the nurse scheduled for about 10 minutes.

The other services the resident utilized were support services which included a once daily "I'm okay" check which was offered as a complimentary service. The other support services in placed included housekeeping and meals. For meals, the resident was independent getting herself to the dining room.

One evening the resident was found deceased in her bed when family visited at 6 p.m. The facility conducted an investigation into the matter and found the "I'm okay" check intended for earlier that day had not been completed as planned. A review of the resident's service plan had no other scheduled assisted living services.

The day prior to the resident's death, the progress notes indicated the home care nurse service had seen the resident and completed her wound cares around 5 pm. The same note indicated a blood draw was performed earlier in the day for laboratory work, an oral antibiotic was in use for a potential wound infection, but no emergent concerns were identified.

Later that same evening, the internal investigation indicated camera footage showed two unlicensed caregivers check on the resident at about 8:30 p.m.

During an interview, unlicensed caregiver #1 stated the resident called for assistance the prior evening. She arrived at the resident's room at about 8:30 p.m. and stated the resident requested assistance to secure a leg bandage, which she did. Unlicensed caregiver #1 stated the resident seemed her normal self, was sitting in her recliner watching her shows, joking and laughing with her. The resident was not yet in her night clothing but was talking about getting ready for bed soon.

The internal investigation indicated when the resident was found deceased the next day, she was in her night clothes in bed and likely passed away in her sleep.

During an interview, unlicensed caregiver #2, who was working the day the resident was found deceased, stated she knocked on the resident's door to complete the "I'm okay" check and found the resident's door was locked that morning around 10 a.m. She then stated she went to get key to unlock the resident's door but got distracted by other tasks and forgot to return to complete the "I'm okay" check.

The death record indicated the cause of death was suspected cardiac arrest.

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: Not Applicable

"Assisted living services" includes one or more of the following:
(1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing;
(2) providing standby assistance;
(3) providing verbal or visual reminders to the resident to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication;
(4) providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises;
(5) preparing specialized diets ordered by a licensed health professional;
(6) services of an advanced practice registered nurse, physician assistant, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;
(7) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;
(8) medication management services;
(9) hands-on assistance with transfers and mobility;
(10) treatment and therapies;
(11) assisting residents with eating when the residents have complicated eating problems as identified in the resident record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed;

(12) providing other complex or specialty health care services; and
(13) supportive services in addition to the provision of at least one of the services listed in clauses (1) to (12).

"Supportive services" means:
(1) assistance with laundry, shopping, and household chores;
(2) housekeeping services;
(3) provision or assistance with meals or food preparation;
(4) help with arranging for, or arranging transportation to, medical, social, recreational, personal, or social services appointments;
(5) provision of social or recreational services; or
(6) "I'm okay" check services.

"'I'm okay' check services" means:

Having, maintaining, and documenting a system to, by any means, check on the safety of a resident a minimum of once daily or more frequently according to the assisted living contract.

Action taken by facility: The facility completed an internal investigation and provided additional training and education to all unlicensed caregivers.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37071	A. BUILDING: _____ B. WING _____	C 04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER PONDS SENIOR LIVING	192 JADE TRAIL NORTH LAKE ELMO, MN 55042

(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 April 28, 2025, Minnesota Department of Health initiated an investigation of complaint #HL370718921C/#HL370719582M. No correction orders are issued.	0 000		