Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL377879522M
Compliance #: HL377878781C

Date Concluded: May 28, 2025

Name, Address, and County of Licensee Investigated:
Aurora Assisted Living
115 Magnolia Avenue West
Saint Paul, MN 55117
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, 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 a resident when they failed to supervise the resident who was walking up the sidewalk to the facility without his cane. The resident fell on a step, struck his head, and passed away two days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. A facility staff member opened the front door onto the porch and observed the resident fall back from the bottom stair. It was snowing and the resident wore Crocs foam footwear. The day programming driver who brought the resident from day programing to the facility did not escort the resident all the way to the door before walking away.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the day program director and family. The investigation included review of the resident record, death record, hospital records,

facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included end stage kidney disease, unsteadiness, deformities of both hands related to arthritis, and difficulty walking. The resident's service plan included assistance with bathing, dressing, escorts, grooming, and medication management. The resident's assessment indicated the resident ambulated independently and required assistance with getting in and out of vehicles. The assessment indicated the resident had a cane that he preferred to use only when at dialysis and specifically declined to use when out at day programming to be as independent as possible. The assessment indicated the resident was a fall risk related to unsteadiness and preference to wear Crocs.

An incident report indicated a staff witnessed the resident slip on snow while coming up the stairs, and fall. The report indicated the resident had a bump on the back of his head, without bleeding and was unconscious for a minute. Staff called an ambulance.

Hospital records indicated the resident came to the hospital with altered mental status, but talking, and became less responsive as time went on. The medical record indicated the resident sustained a closed head injury with loss of consciousness. The records indicated no evidence of a stroke. The resident became unresponsive. Discussion with the family led to a decision to provide comfort cares. The resident passed away two days after the incident.

The resident's cause of death was identified as complications of intracranial hemorrhage (bleeding within the skull) due to a fall to the ground. The hospital notified the medical examiner; an autopsy was not performed.

During an interview, the staff who witnessed the resident fall stated the doorbell rang and she went to the door and saw the day program driver drop off the resident's backpack by the door. The staff stated it was snowing so she stopped to remove her indoor shoes and put on outdoor footwear. The staff stated she opened the door onto the porch and saw the resident falling backward from the bottom step. The staff stated she rushed to the resident, but he hit the sidewalk before she could reach him. The staff stated she saw the day program driver at the end of the sidewalk at the time of the fall. The staff stated the driver and a neighbor assisted her with bringing the resident into the house. The staff called 911 and the nurse.

During an interview, the nurse stated the resident loved going to day programming, which was culturally based and full of activities. The nurse stated the day programming provided transportation to and from the program. The nurse stated it was snowing on the day of the incident, and staff had shoveled and salted several times during the day. The nurse stated staff notified her of the resident's fall as she was driving to the facility to cover a shift. The nurse stated when she got to the facility she observed staff, the driver, and a neighbor carry the

resident into the house. The nurse spoke with the resident, assessed his condition, and took his vitals, which indicated an elevated blood pressure. The nurse stated the ambulance came and took the resident to the hospital. The nurse stated she immediately called the day program director to notify the driver to always walk the resident up the stairs and to the door before leaving.

During an interview, the day program director stated the driver was supposed to escort the resident to the door of the facility. Contact information for the driver was not provided.

During an interview, a family member stated the facility staff took good care of the resident. The family member stated he was sad about the fall and felt that both the staff member and the driver could have done a better job.

During interviews several staff recalled the resident as the light of the facility, who loved being outdoors, gardening, and walking. Staff indicated the resident loved attending adult day programming where he made many friends.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility nurse reached out to the day programming director to make sure the driver always walked the residents to the door before leaving. The nurse reinforced that the driver should provide stand-by assistance until the resident was physically handed off to a staff member inside the facility. The day program director stated he would re-educate all drivers.

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
	37787	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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 May 14, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL377878781C/#HL377879522M. No correction orders are issued.	0 000		