*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL392991080M
**Compliance #:** HL392991203C

**Date Concluded:** July 7, 2025

**Name, Address, and County of Licensee Investigated:**
Hillcrest Terrace
1507 East 41st Street
Hibbing, MN 55746
St. Louis County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Barbara Axness, RN
Special Investigator

**Finding:** Inconclusive

**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 they failed to complete services as directed by the service plan. Staff were to complete a visual safety check of the resident but only spoke to the resident through the door. The resident was later found on the floor with blood and feces around his body and the room. The resident was admitted to the hospital.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was inconclusive. While the resident was hospitalized with gastrointestinal bleeding, it cannot be determined if the actions or inactions of staff resulted in the resident's fall. It was unable to be determined when the resident fell or how long he had been on the floor before he was found by a staff member. As soon as staff identified the change in condition, the nurse was notified, and the resident was sent to the emergency room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures.  Also, the investigator observed the resident's room.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia. The resident's service plan included assistance with medication management and a safety check once per shift. The resident's assessment indicated the resident was independent with activities of daily living.

The facility's internal investigation indicated before the resident was found on the floor, he had not been seen for several hours and did not come to the office for medications or to the dining room for lunch, which was unusual for him. A staff member knocked on the resident's door at 9:35 a.m. but did not enter his room. The resident said through the door that he would come down for medications in a few minutes. Another staff member went to check on the resident at 2:02 p.m. and upon entering his room, found the resident on the floor with his pants at his ankles and blood and stool on and around the resident, on the floor, and in the toilet and tub. A facility nurse assessed the resident and called 911.

The emergency medical services report indicated upon arrival, they observed the resident laying on the ground and the ground was covered in smears of blood. It was reported to EMS the resident had been vomiting blood and the resident reported to EMS having dark tarry stools two days ago.

Hospital records indicated the resident arrived at the emergency room covered in black tarry stool and it was reported he had coffee ground emesis that morning. The resident was transferred to the intensive care unit (ICU) and diagnosed with gastrointestinal bleeding and acute blood loss. The resident also had a brain bleed as a result of the fall. The resident spent four days in the hospital and returned to the facility.

During an interview, an unlicensed personnel (ULP) stated he checked on the resident a little after 9 a.m. but only knocked on the door and the resident verbally responded that he'd be down shortly, and he took his verbal response as he was ok. Another ULP stated the resident did not report any abnormal changes with his bowel movements in the days leading up to the hospitalization and the resident was independent and was not usually the type to volunteer any information about himself or his health status.

During an interview, a facility nurse stated the resident had not reported any changes with bowel movements leading up to being hospitalized. The facility nurse stated while staff should have visually checked on the resident at 9 a.m., the resident's service plan included one safety check per day, and the 9 a.m. check was a medication reminder. When staff completed the

safety check later, the resident was found on the floor and emergency services were immediately summoned.

During an interview, the resident stated he could not remember how long he had been on the floor and could not recall any details from the day he fell.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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**: Yes
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
The facility reported the incident to MAARC. Staff were retrained on proper procedures for notifying the nurse and performing safety checks as scheduled.

**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 |
|---|---|---|---|
| | 39299 | A. BUILDING: _____ B. WING _____ | C 06/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLCREST TERRACE | 1507 EAST 41ST STREET HIBBING, MN 55746 |

| (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<br><br>On June 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL392991080M/ #HL392991203C. No correction orders are issued. | 0 000 | | |