Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326084603M
Compliance #: HL326087895C

Date Concluded: May 16, 2023

Name, Address, and County of Licensee Investigated:
Pioneer Estates
8761 Preserve Boulevard
Eden Prairie, Minnesota 55344
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 the resident when facility staff found the resident unresponsive, did not immediately call 911 and initiate cardiopulmonary resuscitation (CPR). Subsequently, the resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility staff followed protocol; staff called 911 after finding the resident unresponsive and called the nurse. The resident was cool to the touch, rigid, and had blood pooling.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family. The investigation included review of the resident's medical records, and policies and procedures including vulnerable adult, emergencies, and resident death. The investigation also included review of the law enforcement report, the autopsy report, and the medical examiner's investigative narrative.

The resident resided in an assisted living facility in a campus-style setting. The resident's diagnoses included chemical dependency. The resident's service plan included assistance with medication administration and behavior management. The resident's assessment indicated the resident had a history of alcohol abuse. This assessment did not indicate the resident had a history of substance abuse.

One morning, facility staff found the resident unresponsive in his room.

A law enforcement report indicated officers arrived on scene. One officer entered the room and attempted to move the resident. The report described the resident as laying face down in the fetal position directly inside his bedroom door. The resident was stiff, cold to the touch, and had no pulse. The officer canceled the medics and began the death investigation process.

The medical examiner's investigative narrative indicated the resident had no obvious signs of trauma or injury. The resident had rigor mortis present (the gravitational settling of blood which is no longer being pumped through the body after death, causing a bluish-purple discoloration of the skin). Additionally, rigor was present in all muscle groups (stiffening of the joints and muscles of a body a few hours after death). This report identified the manner of death as an accident, and the type of death as drug toxicity.

During an interview, the unlicensed personnel (ULP) described the resident as independent, coming and going from the facility as he liked, any time of day or night. The morning of the incident, the ULP noticed the resident did not come down for coffee, but the overnight staff person had told her the resident had a late night with a friend. The ULP went to the resident's room when he did not come down for morning medication administration. The ULP knocked on the resident's door, but the resident did not answer, so the ULP thought he might still be sleeping. About two hours later, the ULP went back upstairs and knocked again. At this point, the ULP tried getting into the resident's room but could not get the door open very far. The ULP and another ULP were able to get the door opened far enough to see into the room which is when they noticed the resident on the ground. The ULP instructed the other ULP to get the nurse while she stayed at the door. When the nurse arrived, the three staff members pushed the door hard enough to open it to the point where the nurse could get into the room.

During an interview, the nurse stated she had been onsite the morning of the incident. A staff member approached her while working in one of the other facilities on the campus, notifying her of the emergency in the facility where the resident resided. The nurse arrived at the resident's room. The resident had screwed a piece of carpet to the inside of the door, making it hard to open. When the nurse could open the door enough to get inside the room and see the resident laying in a sort of fetal position on the floor, she immediately instructed a staff member to call 911. The nurse described the resident as cold to the touch, without a pulse, and had blue-coloration. The nurse tried pulling the resident back by his shoulders, but his body felt

very stiff. Due to the stiffness of his body, the nurse could not pull him over onto his back to attempt CPR.

During investigative interviews, staff members of facility did not know the resident had been using illegal substances.

During an interview, a family member stated facility staff did a good job in general but wished they could have done a urinalysis to check for drugs, even though he had a history of known drug use, not current. The family member stated they did not know the resident had been using drugs again until a short time before his death.

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

Action taken by facility:
The facility called 911. The facility completed an internal investigation.

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
	32608	A. BUILDING: _____ B. WING _____	C 05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER ESTATES	8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344

(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 2, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL326087895C/#HL326084603M. No correction orders are issued.	0 000		