DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368859687M
Compliance #: HL368857576C

Date Concluded: March 26, 2024

Name, Address, and County of Licensee Investigated:
Kindheart Homes
2400 Chicago Avenue South
Minneapolis, MN 55404
Hennepin 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 the resident when they failed to provide the resident with oxygen and the resident passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had multiple medical diagnoses that contributed to his death. No evidence indicated facility actions or inaction contributed to his death. The resident had recently begun continuous oxygen by nasal canula and told staff he did not like the way the apparatus felt on his face, so he frequently refused to use it. The resident passed away due to a blood clot in his lung.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and reached out to law enforcement. The investigation included review of the resident record, death record, hospital records, medical examiner reports, facility incident reports, personnel files, staff

schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff/resident interactions and resident living conditions.

The resident lived in an assisted living facility. The resident's diagnoses included lung cancer, chronic obstructive pulmonary disease, and deep vein thrombosis (blood clots) in lower legs. The resident's service plan included assistance with showers, meals, transfers, and medication administration. The resident's assessment indicated he was independent with decision making, was alert, and oriented to his surroundings.

A progress note indicated the resident complained of difficulty breathing and staff sent him the hospital. The resident received treatment for pneumonia and a new order for continuous oxygen via nasal cannula. The resident returned to the facility and received the oxygen several days later.

During an interview, a nurse stated the resident was a smoker. The nurse stated she educated the staff and resident on dangers of having smoking materials near his oxygen canister and tubing. The nurse stated two days after starting the oxygen, the resident was outside smoking without his oxygen on and had difficulty breathing. The nurse stated 911 was called, an ambulance arrived, and they took the resident to the hospital.

Hospital records indicated the resident showed signs of breathing difficulty when emergency medical technicians (EMTs) arrived but was coherent and able to communicate. The records indicated the resident's condition changed while enroute to the hospital and EMTs began cardiopulmonary resuscitation (CPR). The records indicated the resident was in cardiac arrest upon arrival to the hospital and passed away after prolonged resuscitation attempts.

During an interview a staff member stated the resident often refused to use his oxygen, as he did the day of the incident. The staff stated the resident made his own decisions and had the right to refuse.

During an interview a family member stated she was concerned the staff did not know how to set up the resident's oxygen and did not clean properly.

The resident's death records indicated the cause of death was a blood clot in his lung.

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.

Action taken by facility:
No action required.

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
	36885	A. BUILDING: _____ B. WING _____	C 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDHEART HOMES INC	**2400 CHICAGO AVENUE UNIT #1 MINNEAPOLIS, MN 55404**

(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 March 18, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL368857576C/#HL368859687M. No correction orders are issued.	0 000		