

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394253081M
Compliance #: HL394253004C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee

Investigated:

Hayden Grove Senior Living
2601 Stinson Parkway
St. Anthony MN 55418-1672
Hennepin County

Facility Type: Assisted Living Facility with
Dementia Care (ALFDC)

Evaluator's Name: Christine Bluhm, 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:

The facility neglected the resident when staff did not supervise the resident after the resident went into her apartment and choked on her food. Staff did not attempt the Heimlich maneuver on the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Facility staff interacted with the resident during the meal and again before she left the dining room. The resident walked out of the dining room and into her apartment without signs she was choking. Video indicated staff checked on her approximately a minute later. Staff found the resident unresponsive, called 911 and followed the dispatcher's instructions until emergency responders arrived.

The investigator conducted interviews with facility administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, facility

internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. The investigator observed staff interactions and supervision in the dining room at mealtime.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with meal preparation but the resident ate independently. The resident's assessment indicated the resident had cognitive impairment and required cues and redirection.

The facility investigation report indicated that over the evening mealtime, a staff member checked on the resident and heard the resident gasping from the resident's bathroom. The staff member found the resident slumped over on the toilet. The staff member saw food in the resident's mouth, tried to remove it and went to get help.

The facility dining room video indicated staff interacted with the resident several times throughout the meal. The resident ate most of her meal, stood up and walked out of the dining room toward her apartment. Although the video does not include audio, it did not appear the resident was experiencing signs of choking at that time. Approximately one minute after the resident left the dining room, a staff member walked out of the dining and in the direction of the resident's apartment.

Review of infrared video captured inside the resident's apartment showed the resident enter her apartment, walked into her bathroom, and closed the door behind her. Approximately a minute later, an image of another person, presumed to be a staff member, walked into the apartment, and entered the resident's bathroom.

During an interview, another staff member who was in the dining room that day, stated the resident did cough some and offered her something to drink. He stated the resident did not show any indication she was choking or in distress when she left the dining room.

During an interview, a facility manager stated a staff member checked on the resident only minutes after she left the dining room. The manager stated the staff member followed the plan of care, called 911 and followed the dispatcher's instructions, which included CPR. Emergency responders attempted to revive the resident, but the resident passed away.

The investigation could not conclude if staff performed the Heimlich maneuver on the resident. The resident's cause of death was choking on food and her manner of death was ruled an accident.

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:

The facility investigated the incident.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39425	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2024
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NAME OF PROVIDER OR SUPPLIER HAYDEN GROVE OF ST ANTHONY	STREET ADDRESS, CITY, STATE, ZIP CODE 2601 STINSON PARKWAY ST ANTHONY, MN 55418
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(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	<p>Initial Comments</p> <p>On May 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL394253004C/#HL394253081M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____