Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL395411722M
Compliance #: HL395412830C

Date Concluded: May 15, 2025

Name, Address, and County of Licensee Investigated:
Alabama Residence
14438 Alabama Ave S
Savage MN55378
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier
Special Investigator

Finding: Substantiated, facility responsibility

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 it had only one staff member working on the night shift, the staff member was unable to attend to a residents call for help, so the resident called 911.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The investigation identified several occasions with only one caregiver working while all residents were a heavy lift or transfer needing two people. On this occasion, the resident called for help, no one responded so the resident called 911 and police responded to his call. The police found the one caregiver onsite had fallen asleep.

While it was true the caregiver on-duty fell asleep, the facility failed to provide a second caregiver on duty to meet the needs of the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff interactions with residents, visitors and other staff.

The resident resided in an assisted living facility. The resident's diagnoses included high blood pressure, coronary artery disease and asthma. The resident's service plan included assistance with medication management, dressing, grooming and bathing. The resident's assessment indicated he had a below the knee amputation and used a wheelchair and is unable to walk.

A police record reports indicated in the middle of the night, the resident called 911 for assistance. The reports states the resident was unable to get staff attention when he needed assistance so after some time, the resident called 911. When officers arrived on site, they were unable to locate a staff member for several minutes. When the officers finally located a staff member, he stated he had fallen asleep and was the only staff member working that night.

A police department incident report dated April 3, 2025, indicated could not get staff's attention and called 911. The same document indicated the resident's 911 call came in at 0248 [2:48 a.m.], the police response was first assigned at 0250 [2:50 a.m.] and the first arrived at 0308 [3:08 a.m.]. The same document indicated the resident reported struggling to get out of bed, could not walk, and could not get a caregiver's attention. First responders could not get a staff members attention for several minutes and the staff member had fallen asleep while on duty.

A staff schedule provided by the facility indicated staff shifts were from 7 a.m.-3:30 pm with 2 employees listed, 3 p.m.-11:30 p.m. with 2 employees working on the night shift 11 p.m.-7:30 a.m., one employee worked from 9pm-1am, leaving one employee working the rest of the shift by themselves.

A facility policy titled Staffing indicated at least two (2) caregivers would be scheduled and available for residents requiring the assistance of two caregivers for scheduled and reasonably foreseeable unscheduled needs as reflected in the assessment and service plan.

The resident's face sheet dated December 28, 2024, stated the resident was non-ambulatory and would need significant assistance in evacuation.

During an interview, a manager stated this occurred because the second employee scheduled that night could only stay until 1:00 a.m. due to personal reasons.

A review of the schedules of other days surrounding this event indicated this had occurred on multiple occasions.

During an interview, the resident stated the night he called 911 for help, only one staff member was working. The resident stated he called for help after falling out of bed, used his call pendant but no caregiver came. The resident stated after 15 or so minutes he called 911 for assistance. The resident stated many times only one staff person works the night shift and that feels unsafe.

During an interview, a nurse stated all the residents are heavy assist of 2 people for transfer help and toileting needs. The nurse also stated it would not be appropriate to have less than 2 caregivers scheduled on all shifts because of the needs of the residents.

The attempts to interview the one caregiver present when this incident occurred were unsuccessful.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: resident was responsible for himself
Alleged Perpetrator interviewed: not applicable

Action taken by facility: The facility terminated the employee.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Savage Police Department
Savage City Attorney
Scott County Attorney
Board of Executive for Long Term Care Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39541	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA RESIDENCY	14438 ALABAMA AVENUE SOUTH SAVAGE, MN 55378

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 44G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL395417862C and HL395412830C/HL395411722M. On April 24, 2025, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving under the provider's Assisted Living license. The following Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following correction order is issued for HL395412830C/HL395411722 with correction order identificaiton: 0470.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 The following correction order is issued for HL395417862C: 0830 with correction order identificaiton: 0830.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and document review, the	0 470		

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0 470	Continued From page 2 licensee failed to provide adequate staffing levels for 4 (R1, R2, R3, and R4) out of 4 residents when there was only one caregiver at the facility. Additionally, during a time of having one caregiver present a resident (R3) called for help but the one facility caregiver present was not awake. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and a current census of 4 residents. R1 R1's diagnoses included high blood pressure and recent below the knee amputation. R1's Face sheet dated December 28, 2024, stated R1 was non-ambulatory and would need significant assistance in evacuation. A police department incident report dated April 3, 2025, indicated a resident [R1] could not get staff's attention and called 911. The same document indicated the police response was first assigned at 0250 [2:50 a.m.] and the first arrived at 0308 [3:08 a.m.]. The same document indicated R1 reported struggling to get out of bed, could not walk, and could not get a staff member's attention. First responders could not get a staff members attention for several minutes	0 470		

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0 470	Continued From page 3 and the staff member had fallen asleep while on duty. On April 21, 2025, at 2:15 p.m. manager-A stated the facility worked short hours on the night shift this occurred. On April 22, 2025, at 1:27 p.m. registered nurse (RN-B) stated it is not appropriate to not have two staff members working at all times because of the needs of the residents. On April 28, 2025, at 1:35 p.m. R1 stated the night he called 911 for help, only one staff member was working. R1 called for help after falling out of bed, used his call pendant but no staff member came. R1 then stated after 15 or so minutes he called 911 for assistance. R1 also stated many times only one staff person works the night shift and that feels unsafe. R2 R2's diagnoses include cerebrovascular accident, wheelchair dependent, and non-ambulatory. R2's face sheet dated August 31, 2023, states R2 is non-ambulatory and would need significant assistance in evacuation. On April 22, 2025, at 1:27 p.m. registered nurse (RN-B) stated R2 transferred with assist of two with an EZ-stand, limited use of her arms due to a history of stroke, and incontinent of bowel. R3 R3's diagnoses include hemiplegia and hemiparesis following cerebral infarction. R3's face sheet dated May 13, 2024, states R3 is non-ambulatory and would require full assistance in evacuation	0 470		

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0 470	Continued From page 4 On April 22, 2025, at 1:27 p.m. registered nurse (RN-B) stated R3 has left-sided weakness, a history of stroke, and required a Hoyer lift for transfers. R4 R4's diagnoses include CVA with left sided hemiplegia and feeding tube. R4's face sheet dated July 16, 2023, states R4 is non ambulatory and would require full assistance in evacuation. On April 22, 2025, at 1:27 p.m. registered nurse (RN-B) stated R4 had a history of stroke and left-sided paralysis. RN-B stated R4 required assist of two for total cares and transferred using a Hoyer lift. A document provider by the facility titled 24-hour monthly schedule dated March 1, 2025, through April 14, 2025, indicated a one week schedule, Sunday through Saturday and covers 3 shifts. a.m.-3:30 p.m., 3 p.m.-11:30 p.m., and 11 p.m.-7:30 a.m. On this schedule, manager-A was scheduled to work as the 2nd employee working on the 11 p.m. -7:30 a.m. Sunday, Monday, and Saturday. However, the same schedule indicated manager-A was scheduled as the 2nd employee to work from 9-pm - 1 a.m. Tuesday, Wednesday, Thursday, and Friday leaving only one caregiver at the facility from 1 a.m. onward for the rest of the night shift. The licensee's Staffing policy dated August 1, 2022, states at least two (2) home health aides will be scheduled and available for residents	0 470		

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0 470	Continued From page 5 requiring the assistance of two home health aides for scheduled and reasonably foreseeable unscheduled needs are reflected in the assessment and service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with state and local governing laws. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 830		

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0 830	Continued From page 6 The findings include: During facility tour on April 14, 2025, from 12:52 p.m. through 1:31 p.m. with registered nurse/manager (RN)-B the surveyor observed a wooden ramp on the exterior of the facility that led from the front yard near the front door, around the side of the facility. The ramp turned around the back of the facility and ended at a patio in the rear yard. During interview from 1:32 p.m. through 1:43 p.m. with registered nurse/manager (RN)-C, the surveyor asked about the wooden ramp. RN-C stated the construction on the ramp started prior to the facility applying for assisted living licensure in 2022. RN-C stated the previous owner had started work on the facility to start an assisted living but did not follow through. On April 25, 2025, at 12:24 p.m. the surveyor called the local certified building official (CBO)-D to confirm if building permits had been issued to the facility. Surveyor requested additional information and scheduled a call for the following Monday. On April 28, 2025, at 11:08 a.m., CBO-D emailed the surveyor two photos of the exterior of the facility. On April 28, 2025, at 1:14 p.m. the surveyor called CBO-D to continue the interview. CBO-D stated they had received a building permit application from the facility to construct a wheelchair ramp. CBO-D stated they responded to the applicant requesting additional information such as a lot survey and permit checklist but no further documents or communication was received from the applicant. CBO-D stated the	0 830		

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0 830	Continued From page 7 ramp was constructed without a building permit being issued and the applicant did not request any inspections during construction. Surveyor asked CBO-D when the ramp was constructed and CBO-D stated they would look at photos they had taken at the facility, which had the dates on them. Surveyor requested copies of the photos, building permit documents, and any other information CBO-D had that related to the facility. Call ended at 2:07 p.m. CBO-D emailed the surveyor on April 28, 2025, at 2:52 p.m. Attached in the email were two additional photos, building permit printout, and a fire report from a garage fire at the facility. Under MN Rules 1300.0120, an owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. MN Statute 144G.09 requires any construction or alteration to a licensed assisted living facility must also submit plans and apply for plan review and approval from MDH before any construction work can commence. MDH did not receive any plans or application from licensee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		

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02360	Continued From page 8	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		