Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294981709M
Compliance #: HL294982722C

Date Concluded: September 10, 2025

Name, Address, and County of Licensee Investigated:
Good Samaritan Society
Northwind's Assisted Living
2101 Keenan Drive
International Falls, MN 56649
Koochiching County

Facility Type: Assisted Living Facility (ALF)

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: It is alleged the facility neglected the resident when it did not train staff members how to assist with the resident's left ventricular assist device (LVAD)also known as a heart pump. The resident asked staff for help when the LVAD was beeping, disconnected the drive line on the controller of the LVAD which caused it to stop pumping and went into sudden cardiac arrest. The resident later died at the hospital.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The service plan indicated the facility assisted the resident with medication management and the resident was responsible for maintaining the LVAD device which included all functions and operation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed caregivers. The investigation included review of the resident record, death record, facility incident reports, personnel files, staff schedules, law enforcement

reports, clinical notes, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents during a visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure with an LVAD implanted in 2022 and diabetes. The resident's service plan included assistance with medication administration and housekeeping. The resident's assessment indicated the resident was independent with mobility and required an LVAD to stay alive. The resident's cognitive assessment indicated he was alert and oriented with some memory issues.

The facility incident event note indicated the resident received medication around 10:30 p.m. for back pain. About a half hour later, the resident paged again because his LVAD monitor beeped "low battery." The on-duty unlicensed caregiver reminded the resident that she was untrained with the LVAD, and the resident acknowledged the caregiver was not trained but tried to help. She was asked to check the wall plugs for the mobile unit and battery charge; both were plugged in and receiving power. The resident asked for the extra controller to switch over. The caregiver helped straighten some tangled cords and the resident switch the cords to the new controller. Then resident tried to remove the driveline (red button) to switch over. While attempting to call the number listed on his red bracelet, the resident passed out and staff called 911.

A police report indicated that police were called to the facility for a 911 call. The report noted that upon arrival, the resident was unresponsive and learned the controller unit on the LVAD had been swapped out. The officer chose to swap the LVAD control unit back to the one that had been removed and nothing happened. The officer followed the cord and observed that the unit itself was not plugged into the wall, which he then plugged into the wall and observed the control unit turn on and began working. Another officer arrived on scene, and they started CPR.

During an interview, the caregiver stated the resident paged and requested pain medication. Approximately thirty minutes later, the resident paged again and stated he needed help with his heart pump. The device was beeping "low battery." The caregiver said she told the resident that she was not qualified to work the device but observed the resident confused at that time, which was not typical for him, and attributed it to the pain medication. The resident was troubleshooting the monitor and not the battery pack while she, the caregiver, had no training on what to do with the heart device. The caregiver stated the resident passed out while attempting to call the number on his bracelet that had a phone number on it so she called 911, the nurse and the supervisor.

During an interview, the nurse stated the resident admitted to the facility for medication management, could independently manage the LVAD and attended appointments at the clinic for the dressing changes. The nurse stated the resident had a memory lapse one time when he had not remembered to plug in his LVAD, and it was beeping. He asked her for a screwdriver so that he could open and remove the drive unit instead of plugging the unit into the wall. The nurse reviewed the steps in the LVAD manual with the resident and then resolved the beeping

alarm himself. The nurse guessed that this may have been similar to what happened the night of the incident. It was described to her as if he wanted to pull out the drive unit, which would have shut the unit down. Around that time, the resident was sent to the local hospital for a cognitive evaluation. The hospital spoke with the LVAD team (at the U of M) on what concerns to be aware of, they cleared him, and he returned to the facility.

During interview, a facility nurse consultant stated that he would not have admitted to the facility if he had not been able to manage the LVAD on his own. On admission, the resident's BIMS score, (Brief Interview for Mental Status), a tool used to assess cognitive function, was 15, a perfect score.

During interview, an LVAD hospital coordinator stated patients with an LVAD device are expected to be able to manage the device independently whether they are living independently in the community or in an assisted living. The coordinator did acknowledge that the resident had shown some decline in his ability to care for himself around at that time.

During interview, a family member stated the LVAD was an intricate device and was specialized to the University of Minnesota hospital. Special training was required to care for the main drive line, but the resident could change the batteries on the device. He stated the resident did have cognitive decline which triggered to the move into the facility but still could drive himself around town on his own.

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 has updated their admission policy and will no longer accept those with an LVAD device.

Action taken by the Minnesota Department of Health: None 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
	29498	A. BUILDING: _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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 June 5, 2025, the Minnesota Department of Health initiated an investigation of complaint # HL294982722C/ HL294981709M. No correction orders are issued.	0 000		