Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304226081M
Compliance #: HL304228840C

Date Concluded: February 7, 2025

Name, Address, and County of Licensee Investigated:
Wesley Residence
5601 Grand Avenue
Duluth, MN 55807
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Inconclusive

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 Allegations:
The alleged perpetrator (AP), who was an unlicensed caregiver, neglected the resident when she failed to complete scheduled checks on the resident during the night and early morning. The resident was found deceased in the morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The AP's documentation of the completed safety checks conflicted with when she stated she completed the checks. Additionally, there was possible inconsistency between the timing of the last documented safety check and the condition in which the resident's body was found. While the information was conflicting, it was not known how or if it was related to the timing of the resident's death.

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

incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed interactions between residents and staff during a facility visit.

The resident resided in an assisted living facility. The resident's diagnoses included paranoid schizophrenia, heart disease and diabetes. The resident's service plan included assistance with bathing, and reminders for grooming, toileting and changing his incontinence brief. The resident's assessment indicated the resident required assistance with his CPAP (continuous positive airway pressure; machine that uses mild air pressure to keep airways open during sleep) and medication administration. The resident was independent with ambulation and had a call button connected to the wall in his room which was used to call for assistance.

An incident report indicated the resident was found around 8:00 a.m. having deceased sometime prior. Overnight the resident had safety checks scheduled every two hours, however there was no documentation they were completed from midnight to 6:00 a.m.

The facility staffing schedule indicated the AP worked the 6:00 p.m. to 6:00 a.m. shift that day and was the only staff listed for the overnight.

The nursing progress note indicated the resident was found deceased after the AP had left for the day. The manager called the AP, and the AP stated she saw the resident in bed by shining her phone light at 4:30 a.m. and again at 5:30 a.m. during her shift.

The resident's record indicated the AP documented she completed safety checks at 9:08 p.m., 11:12 p.m., 11:27 p.m., 12:42 a.m., 6:24 a.m., and 6:31 a.m.

The police report indicated the resident was found face down between the toilet and a radiator in the bathroom. The resident had a large forehead laceration and knee abrasions along with blood smears on the nearby cabinet drawers.

During an interview, an unlicensed caregiver stated she received shift report from the night staff [the AP] that morning. She stated the AP said that safety checks were completed and with no resident issues overnight. Then around 8:00 a.m., the caregiver stated the resident was found deceased, cold to the touch with dried blood smeared on the floor.

During an interview, a nurse stated the resident's safety check record indicated the AP document completion of the safety checks for that shift but not in "real time". The nurse stated she did not find evidence the safety checks were left undone. The nurse stated the resident was independent and one of the purposes of the safety check was to verify the location of the resident at the time of the check.

The resident's death certificate lists the manner of death as natural, and the cause of death was due to heart disease.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No, the AP did not return requests for an interview.

Action taken by facility: The facility obtained statements from the AP and the morning staff. The facility held a mandatory all staff meeting that included a review of the importance of visual safety checks and documentation in real time. The AP no longer worked at the facility.

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
	30422	A. BUILDING: _____ B. WING _____	C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVENUE DULUTH, MN 55807

(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 January 7, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304226081M / HL304228840C. No correction orders are issued.	0 000		