Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201142642M
Compliance #: HL201144607C

Date Concluded: July 25, 2025

Name, Address, and County of Licensee Investigated:
Ecumen Lakeview Commons
1200 North Lakewood Drive
Maplewood, MN 5519
Ramsey County

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

Evaluator's Name: Willette Shafer, 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 Allegation(s):
The alleged perpetrator (AP) neglected the resident when the AP failed to follow the resident's care plan. After the AP left the resident in her wheelchair unsupervised in her apartment, the resident tried to get out of her chair and fell. The resident broke her hip and died a few days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident was agitated trying to grab at people during dinner. AP-1 and AP-2 brought the resident to her room to help her calm down. Staff often brought the resident to her apartment to decease stimuli and was indicated as an intervention on the resident's care plan. AP-1 and AP-2 were unaware the resident's care plan changed three days prior to the incident and indicated the resident should remain in common areas.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family member. The investigation included review of the resident's records, family member's documentation, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff providing cares to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident received hospice care and was declining mentally and physically. The resident's service plan included assistance with grooming, toileting, meals, assist of one to ambulate but staff should use a full body mechanical lift when tired.

Hospice notes written one month prior to the incident indicated the resident continued to decline physically and mentally. The resident's cognitive score declined on all assessments. She was more confused, easily agitated around other residents, and her hallucinations increased. She continued to have a steady decrease in weight, cheeks sunken, unable to ambulate and required a wheelchair. The resident had multiple falls since hospice admission and was more agitated during meals.

The hospice plan of care updated one week prior to the incident indicated the resident used a wheelchair (Broda) for mobility and transferred with assist of one. The resident required assistance from one staff for meals and grooming. Staff should reapproach the resident when agitated. The resident's behavior triggers included loud, busy environments, and fast movements.

The resident's care plan updated three days before the incident indicated the resident should remain in common areas in Broda chair while awake. The care plan also indicated the resident should be brought to her apartment when agitated as a family member reported "she will usually calm down when alone."

An email correspondence sent between the family member and a member of management indicated three days before the incident a staff member left the resident in her apartment unsupervised, and the resident slid out of her recliner. Management's response to the family member indicated management would re-educate staff on the resident's care plan and require a signed acknowledgement of understanding.

A meeting note documented two days before the incident indicated the resident's family member requested the resident remain in common areas in her Broda chair unless she was in bed. The facility agreed to accommodate the family's request when the resident was calm but indicated when the resident was restless or over stimulated the resident would be brought to her apartment to calm down. The family member was aware the facility was unable to provide one to one staffing to prevent falls and the resident remained at risk for falls even in the common area.

The resident's progress notes indicated the care plan was updated two days before to include the resident should not be left alone in her apartment unless she was in bed. The resident should remain in the common area the resident was in bed, cares were being completed, or her family member was present.

The internal investigation indicated AP-1 assisted the resident with dinner in the dining room. During dinner, the resident was agitated, grabbed at people, and appeared tired. AP-1 and AP-2 brought the resident to her apartment, completed cares, and assisted her into the recliner in her apartment to rest. AP-1 and AP-2 reported they thought the quieter, familiar environment would help the resident feel calmer. AP-1 and AP-2 left the resident's door open, so she was easily observed. The resident was found shortly after AP-1 and AP-2 left on her apartment floor. While the resident was lifted off the floor with a full body lift, the resident's family member arrived. The resident reported pain in her hip.

A progress not written by hospice one day after the incident indicated the resident's leg had a possible fracture. The provider was updated, and an order was written for an x-ray. The family member declined the x-ray and wanted to continue comfort cares.

The resident's progress notes indicated the facility reported concerns the family had with the resident's pain management and the provider adjusted her medications several times during the end of her life.

During an interview, a member of management said the resident's service plan was recently updated to include keeping the resident in common areas in her Broda chair and the resident should not be left in her apartment unattended. She said staff received verbal education on the new intervention. She also said when changes are made to an electronic care plan the system highlighted the change and required staff to acknowledge understanding.

During an interview, a member of management who was also a nurse said the resident was on hospice and rapidly declining. The resident had several falls including sitting herself on the floor while at the facility. Numerous interventions were implemented including increased supervision and increased assistance with transfers. The family member also placed a camera in the resident's room to monitor the resident's movement. The family member met with facility staff a couple days before the incident and discussed new interventions to keep the resident safe. The nurse said the family member was aware the resident became agitated and restless in loud environments and her apartment was safer for her during these times. She told the family the facility was unable to provide a staff member to always remain in the resident's apartment with her.

During an interview, AP-2 said AP-1 brought the resident to her apartment after dinner and they both assisted her with cares and put the resident in her recliner. AP-2 continued to assist the resident in her apartment, while she left to help another resident. She said she did not have

time to look at the resident's care plan before she started her shift, and nobody told her the resident's care plan changed. She received a brief report from the outgoing staff before her shift, but the report failed to mention the resident was no longer able to sit in her recliner in her apartment. Before this incident, the resident often sat in the recliner in her apartment. After the resident fell, the nurse told AP-2 the care plan changed and showed her in the service plan. The notes area of the service delivery record indicated the resident should remain in common areas. The information was documented under a service scheduled later in the evening, after the incident (therefore the system alert did not provide the note prior to the incident). AP-2 was assigned to medication administration on the day of the incident and the new intervention was not visible on the medication administration record. AP-1 was assigned medication administration the day before the incident, so she was unaware of the change also. After the incident, management sent a message via text to AP-2 indicating the resident was unable to be left in her apartment unsupervised.

During an interview, AP-1 said she never received any report on the resident before her shift started. After dinner, AP-1 and AP-2 assisted the resident to her recliner in her apartment. Shortly after moving the resident to her recliner, she found the resident on her apartment floor. AP-1 and AP-2 assisted the resident off the floor with a full body lift while her husband was present. AP-1 said every Monday management reported on each resident. She said management told staff the resident was supposed to be in her Broda chair when out of her room and she was recently changed to a full body lift but denied she was told the resident was unable to be left alone in her apartment.

During an interview, a family member said he visited the resident daily. The resident received hospice services and had lost 30 pounds over the last six months. Two days before the incident, the family met with the care team and discussed keeping the resident in common areas, so she was easily observed. On the day of the incident, the family member arrived as staff were assisting the resident off the floor with the full body lift. An x-ray was ordered but not completed because the resident was on hospice and not a good candidate for surgery. Hospice staff took pictures of the resident's hip, and the resident was placed on comfort cares. The family member said the cameras in the resident's apartment were not recording during the incident. After the resident died an autopsy was completed and indicated the cause of death was natural causes. The family member requested the medical examiner receive the resident's medical record to show the resident fell. The family member was also concerned about issues with the resident's pain medications.

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, she was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP-1 and AP-2 were interviewed.

Action taken by facility:
The facility reported the incident to the appropriate people. The facility completed an internal investigation and follow-up education was completed with facility staff.

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
	20114	A. BUILDING: _____ B. WING _____	C 06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKEVIEW COMMONS	1200 NORTH LAKEWOOD DRIVE MAPLEWOOD, MN 55119

(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 20, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201144607C/#HL201142642M. No correction orders are issued.	0 000		