DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201146482M
Compliance #: HL201149665C

Date Concluded: December 23, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Lakeview Commons
1200 North Lakewood Drive
Maplewood, MN 55119
Ramsey County

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

Evaluator's Name:
Brandon Martfeld, RN, BSN, 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(s):
The facility neglected resident #1 and resident #2 when they failed to provide appropriate supervision for resident #1 and resident #2. As a result, resident #1 and resident #2 had an altercation that led to resident #1's fall and a fractured pelvis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the altercation between resident #1 and resident #2, staff were providing the residents with appropriate supervision. The altercation between resident #1 and resident #2 was a sudden and unforeseen event between resident #1 and resident #2.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident #1 and resident #2 records, resident #1 hospital records, facility internal investigation, facility incident reports,

staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

Resident #1 resided in an assisted living memory care unit. Resident #1’s diagnoses included dementia. Resident #1’s service plan included assistance with reassurance/redirection, dining escorts, and safety checks three times a day. The resident was independent with transfers and required standby assistance with a walker when walking outside of her apartment. The resident’s assessment indicated the resident had cognitive impairment and was not able to report abuse.

Resident #2 resident in an assisted living memory care unit for approximately four days. Resident #2’s diagnoses included Alzheimer’s disease and Lewy body dementia. Resident 2’s service plan included assistance with safety checks three times a day and assistance with being redirected to her apartment when agitated or irritable. Staff were to monitor the resident for signs of irritation or agitation which included when resident #2 twiddled her fingers or had agitated facial expressions. The resident was independent with transfers and walking, had cognitive impairment, and was not able to report abuse.

A seven minute and 13 second video with no sound was reviewed from the facility’s camera pointing toward the end of hallway with the lower portion of resident #1’s apartment door in the forefront of the video. When the video began both residents were in the common area, resident #1 standing next to resident #2 who was sitting in a glider chair. A staff member stood in front of both residents having a conversation. After approximately 15 seconds, the staff member left the hallway and walked out of site. About 30 seconds into the video, resident #1 sat down in a glider chair next to resident #2. Resident #1 and resident #2 appeared to be having a pleasant conversation for approximately three to four minutes. Next, resident #1 stood up from the glider chair and walked down the hallway out of sight. Approximately one minute later, resident #1 walked back towards resident #2. As resident #1 walked through the common area to her apartment door, resident #2 stood up from the glider chair and attempted to pick something up off the floor. Simultaneously, resident #1 walked around resident #2 to enter her apartment. Without warning, resident #2 suddenly followed behind resident #1 who was shutting the apartment door. The video showed resident #2 pushing on resident #1’s apartment door against resident #1 who was attempting to shut the door. Next, the video showed the door close with both resident #1 and resident #2 in resident #1’s apartment. Approximately one minute later, the video showed a facility staff member entering resident #1’s apartment. The staff member can be seen leading resident #2 out of resident #1’s apartment across the hall and to resident #2’s apartment that was out of the video view.

The facility incident report indicated one evening resident #1 was screaming out for help. When a nurse entered resident #1’s apartment, resident #1 was on the floor, and both resident #1 and resident #2 were pulling on a kitchen apron. The nurse escorted resident #2 out of the apartment and into her own apartment. The incident report indicated resident #1 was transferred to the hospital for an evaluation.

Hospital records indicated resident #1 sustained a right pelvic fracture and bruising to her right elbow. Resident #1 was hospitalized for three days and transferred to a higher level of care.

During an interview, the nurse stated during a safety check for resident #2, screaming was heard from resident #1's apartment. Upon entering the apartment, resident #2 was standing while holding onto one end of a kitchen apron and resident #1 was on the floor holding the other end of the kitchen apron. The nurse stated they intervened and escorted resident #2 back to her apartment. Resident #1 was checked on after resident #2 was in her apartment. The nurse stated they did not see how the incident started.

During an interview, leadership stated resident #1 came out of her apartment and had talked with resident #2. At some point resident #1 returned to her apartment and resident #2 followed her as if "following a friend." Leadership stated resident #1 and resident #2 did not have any altercation before the incident. Following the incident, resident #2 was escorted back to her room, and resident #2's family member stayed with her for the evening. Three days after the incident, resident 2's family member transferred resident #2 to a behavioral health unit. Leadership stated it was not clear what occurred between resident #1 and resident #2 after resident #1's apartment door closed.

During an interview, resident #1's family member stated there had not been an incident like this before between resident #1 and resident #2. Resident #1 sustained bruises and a fractured pelvis after the incident with resident #2. Following the incident, resident #1 was hospitalized, transferred to a transitional care unit, and to a different memory care unit.

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. Resident #1 no longer resided in the facility. An interview with resident #2 was attempted but could not be completed due to cognition.

Family/Responsible Party interviewed: Yes. Both resident #1 and resident #2 family members were interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Following the incident, resident #2 was escorted to her apartment. Resident #1 was transported to a hospital.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20114	A. BUILDING: ______ B. WING ______	C 12/02/2024

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 December 2, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL201149665C/#HL201146482M. No correction orders are issued.	0 000		

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