Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201146483M
Compliance #: HL201145175C

Date Concluded: October 20, 2025

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

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected the resident when the AP failed to assist the resident to the bathroom per her care plan. The resident attempted to walk to the bathroom independently, fell, and broke her leg.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP started her shift in the memory care unit at 10:40 p.m. Video surveillance showed the AP spent her entire shift in the activity room until the resident fell at 1:24 a.m. The AP failed to assist the resident to the toilet at 12:00 a.m. per the resident's care plan. At 1:24 a.m., the resident attempted to transfer herself to the toilet, fell, and broke her leg. The AP failed to provide all scheduled services and care to the residents in the memory care unit before the incident.

The investigator conducted interviews with facility staff members, including administrative nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's records, hospital records, facility internal investigation, video surveillance, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff members providing care including toileting residents while onsite.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, anxiety, depression, diabetes, and glaucoma. The resident's service plan included assistance with toileting, assistance of one staff while walking, grooming, redirection, and safety checks. The resident's assessment indicated she was at an increased risk for falling and several interventions were added to her care plan to prevent falls including scheduled routine toileting.

The resident's care plan indicated the resident received a scheduled toileting service at 12:00 a.m. The service plan also indicated the resident received scheduled safety checks at 11:00 p.m.

The resident's progress notes indicated the AP heard the resident "screaming." The AP found the resident on her apartment floor and reported she fell while trying to get to the bathroom. The resident reported she hit her head and heard a cracking sound when she fell. The resident was distressed and reported intense pain in her head and leg. The AP called the triage nurse and then emergency medical services. The resident was transported to the hospital via ambulance.

Video surveillance from a memory care hallway showed the AP arrived in the memory care unit at 10:41 p.m. and entered the activity room. (Activity room was right next to the entrance/exit memory care door.) The video showed the AP left the activity room at 11:55 p.m., exited through the memory care unit door and returned to the memory care unit at 11:58 p.m. with a drink and small bag. She went directly into the activity room (roughly ten feet from memory care door). The AP was not observed leaving the activity room again until 1:24 a.m. The video showed the AP never provided any services or checked on the residents from 10:41 p.m. until 1:24 a.m.

The internal investigation indicated the AP heard the resident yelling in her apartment at 1:24 a.m. The AP observed the resident on her apartment floor and the resident reported she got up to use the bathroom and became dizzy. The resident reported she "heard a cracking" sound. The triage nurse was notified, and emergency services were called. The AP failed to complete a 12:00 a.m. toileting service. The AP reported she was assisting another resident at 12:00 a.m. The resident was diagnosed with a femur fracture at the hospital.

The resident's hospital record confirmed the resident broke her femur (thigh) bone and required surgery. A few days after surgery was competed, the resident was discharged to a transitional care unit.

During an interview, an unlicensed staff member said she was assigned as the float staff to assist in the memory care unit when a second staff was needed for two person assists. She said the staffing pattern for the memory care unit was normal during the night of the incident. She said she was never called to the memory care unit before the incident to assist with any cares. She assisted with the incident after the resident fell.

During an interview, a member of management said the resident was assessed as an increased risk for falling and several interventions were added to the resident's care plan to prevent falls including time specific toileting services. After the incident was reported, management reviewed the video footage and found the AP failed to complete services for all memory care residents before 1:24 a.m. The AP was observed in the activity room from 10:41 p.m. until 1:24 a.m. only coming out one time to get, what appeared to be, food. The AP never completed the resident's 11:00 p.m. scheduled safety check or a 12:00 a.m. scheduled toileting service. However, the AP falsely documented she completed all the resident's scheduled services in the resident's chart before the incident. The AP received all required training.

During an interview, the AP she was assigned to provide the resident's care the evening of the incident. While the AP was in the activity room, she heard the resident "screaming really loud". When she arrived at the resident's room, she observed her lying on her floor. The resident reported she fell while trying to take herself to the bathroom and she heard a "crack." The AP called the triage nurse who directed her to call emergency medical services. The resident was taken to the hospital. The AP said she never took the resident to the bathroom or saw her before the incident. She said she does not remember providing any services to the memory care residents before the incident. She understood how to use Point of Care (system facility used to view and document services) including documenting on the resident's scheduled services. She acknowledged she documented she provided services that she never completed and stated she planned on going back to do them later.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, due to cognitive deficit.
Family/Responsible Party interviewed: No, she declined the interview and stated she had no further information to add.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department

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 10/10/2025

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.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: HL201145175C/HL201146483M On October 10, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 93 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL201145175C/HL201146483M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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 10/10/2025

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
02360	Continued From page 1 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 an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		