*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL203815384M
**Compliance #:** HL203817387C

**Date Concluded:** November 8, 2024

**Name, Address, and County of Licensee Investigated:**
Brookdale of Edina
3330 Edenborough Way
Edina MN 55435
Hennepin County

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

**Evaluator's Name:** Maggie Regnier
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 alleged perpetrator neglected the resident when an inappropriate fall intervention was put in place.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Although an inappropriate fall intervention was briefly in place when the alleged perpetrator placed a chair behind the resident's wheelchair to prevent her from tipping backward, the error was an isolated incident, corrected quickly and no harm occurred to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the resident records, facility records including internal investigation records, policies, and training records. Also, the investigator observed staff

interactions with other staff, residents, and visitors. Also, the investigator observed the area where the incident took place.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, heart disease and weakness. The resident's service plan included assistance with daily care activities and use of wheelchair for movement within the facility. The resident's assessment indicated she had recent falls and needed assistance with ambulating short distances but could become impulsive which could increase her risk of injury if not assisted with transferring.

One day the AP placed a chair behind the resident's wheelchair, while the resident was sitting at a dining table, to prevent the resident from rolling back and potentially hurting herself by tipping over the wheelchair. However, the chair was removed shortly afterwards by a supervisor working in the area who noticed the chair. The resident's medical record indicated resident was taken to her room and assessed to have no negative effects from the situation.

During an interview, a manager indicated that the alleged perpetrator along with other staff members did not realize placing a chair behind the resident's wheelchair could be considered a restraint. The facility provided re-education to staff members to prevent recurrence.

During an interview, a nurse stated the restraint policy was reviewed, along with this incident with staff, and provide re-education to prevent recurrence.

During an interview, the alleged perpetrator stated she did not know that placing a chair behind the resident's wheelchair could be a restraint. The alleged perpetrator stated she just wanted the resident to be safe and prevent a fall.  The alleged perpetrator stated she now understands how this was a restraint and would not do so again.

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, dementia
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility reported this incident and did re-education of all staff on what is a restraint.

**Action taken by the Minnesota Department of Health:**
No further action 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 |
|---|---|---|---|
| | 20381 | A. BUILDING: _____ B. WING _____ | C 10/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE EDINA | 3330 EDINBOROUGH WAY EDINA, MN 55435 |

| (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<br><br>On October 8, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL203817387C/#HL203815384M. No correction orders are issued. | 0 000 | | |