Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218036583M
Compliance #: HL218039864C

Date Concluded: December 30, 2024

Name, Address, and County of Licensee Investigated:
Brookside Senior Living
804 Benson Rd
Montevideo, MN 56265
Chippewa County

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

Evaluator's Name: Lena Gangestad, RN
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 the resident when the resident fell, required hospitalization, where a fracture was identified along with severe constipation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did fall in her room, the facility fell and was found on the floor, however the facility sought appropriate care in response to the fall. At the hospital, the resident was found to have severe constipation which was treated there. The resident did have medications prescribed for her on an as-needed basis at the facility, however the facility had not observed any recent symptoms nor had the resident requested these medications.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses include dementia and diverticulosis. The resident's service plan indicated resident needed assistance with medication administration, morning and bedtime care, including grooming and dressing. The service plan at the time of the fall did not include any over night cares or safety checks.

A fall incident report indicated the facility caregiver(s) heard a faint call from the resident's apartment one night at approximately 2 AM. The same document indicated the resident was found near her bed in pain, so she was transferred to the hospital via 911.

The hospital records indicated the resident admitted for a lumbar compression fracture, which was described as mild and stable, and altered mental status. The hospital also diagnosed the resident with severe constipation. To address the fracture and fall, physical and occupational therapy were scheduled for follow-up. During the hospitalization, the resident's medications were reviewed, and several medications were discontinued due to their potential to cause fatigue or confusion. For chronic constipation, the records noted that Lactulose might be causing nausea before bowel movements, so it should be used as needed. Senokot and daily MiraLAX are to be continued as prescribed.

Prior to the fall, the resident's medications as prescribed at the facility included docusate capsules once daily as needed, glycerin suppositories once daily as needed, and Polyethylene Glycol powder as needed, which were medications to help prevent constipation.

Also, prior to the fall, the medication administration record indicated the docusate capsule were administrated once two weeks prior the incident happened.

During an interview, the family member stated that the resident fell and was sent to the hospital. She said that the resident complained of abdominal pain at the hospital, where it was discovered that she was severely constipated.

A review of the resident's facility progress notes prior to the fall, there was no indication that the resident had complained of symptoms of constipation such as abdominal discomfort.

During an interview, the unlicensed caregiver #1 stated that the resident was alert but became more confused prior to the incident. She said the resident had a laxative prescribed on an as-needed basis, and she would administer the medication if the resident expressed a need for it or complained about constipation. She said the resident rarely complained about constipation and did not say anything about it before the incident.

During an interview, the unlicensed caregiver #2 stated that the resident did not complain about constipation to her before the incident.

During an interview, unlicensed caregiver #3 stated that she did not remember whether the resident complained about constipation. She said that she knew the resident had laxative powder for it but, to her knowledge, had not requested it.

During an interview, a manager stated the facility tracking bowel movements was not on all resident's service plans as it was an extra service and had to be added, which had not been added to the resident's service plan. Since it was not part of her plan, the facility relied on the resident's reports since the laxatives were prescribed "as needed" and not a scheduled medication.

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, the resident was in transitional care unit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility followed protocol and sent the resident to the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21803	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE SENIOR LIVING	804 BENSON ROAD MONTEVIDEO, MN 56265

(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 18, 2025, the Minnesota Department of Health initiated an investigation of complaint HL218036583M/HL218039864C. No correction orders are issued.	0 000		