State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273985382M
Compliance #: HL273982600C

Date Concluded: March 12, 2026

Name, Address, and County of Licensee Investigated:
Ecumen Seasons of Maplewood
1670 Legacy Pkwy E
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Deb Schillinger 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 the resident when supervision was not provided while sitting up in wheelchair and she fell.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. It was true the resident was placed in her wheelchair by caregivers and later was found on the floor. However, the caregivers helped the resident position herself in the chair before leaving the room as shown by a video. The next video occurs approximately 75 minutes later and how the resident fell is unknown. When the caregivers checked on the resident she was on the floor. The facility took appropriate steps to coordinate cares with hospice afterwards.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice caregiver. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between residents and facility caregivers during an onsite visit.

The resident resided in an assisted living memory care secured unit. The resident's diagnoses included dementia, heart and kidney disease. At the time of the fall, the resident's service plan included

assistance with transfers of one person, behavior monitoring every 2 hours, redirection, and toileting. The resident's assessment indicated the resident was not able to use the call system for assistance, fell frequently, and experiencing progressive physical decline.

A concern arose unlicensed caregivers transferred the resident to the wheelchair, then left the room, and the resident fell just minutes later because the resident was not placed in the wheelchair properly.

The resident had resided at the facility for approximately thirty-one days before the fall and was receiving hospice services for a dementia related diagnosis. Hospice admission documents report progressive decline in condition since hospice admission. The same document indicated she at times leaned to the side in her wheelchair as she had difficulty sitting upright. The hospice plan of care indicated the hospice nurse would instruct caregiver on safety measures as applicable.

There were two videos relevant to this event available.

Video #1
Before the fall, a time-stamped video at 2:27 p.m., with hospice caregiver present, showed two facility caregivers who transferred the resident from sitting on the edge of the extended recliner to a wheelchair. The two facility caregivers then repositioned the resident to be seated farther back in the wheelchair. The two facility caregivers then left the room, while the hospice caregiver remained with the resident. When alone, the video showed the resident at times leaning forward in the wheelchair and then leaning back again. The resident leaned forward while the hospice caregiver was in the room. After 2 minutes the hospice caregiver also left the room.

Video #2
Approximately 75 minutes after the caregivers left the room, a new video began, time-stamped at 3:55 p.m. and the resident was on the floor, with only the resident's legs in camera view. The resident's wheelchair is turned slightly from the previous video, but in the same area of the room. The video continued showing facility caregivers assisting the resident from the floor using a mechanical lift and transferring into the wheelchair. The resident's injuries included bruising to her forehead and a skin tear to her forearm.

The videos reviewed did not include the resident's fall itself.

The incident report timestamped at 3:55 pm indicated a caregiver entered the room to provide cares for the resident and found her on the floor. The same document indicated the resident could not explain what occurred.

After the fall, the facility held a care conference with family members and hospice case manager. The same document indicated hospice agreed to schedule pain medication, offered a personal alarm and to send a volunteer the next week and could visit once weekly.

Facility incident reports indicated the resident had four prior falls since admission to the facility. After each fall, the facility notified hospice and medical providers, reviewed current service plan and added new interventions as needed.

The facility Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) indicated safety checks every 2 hours are available, bed alarms or movement sensing technology was not a service provided at the facility.

The resident passed away about three weeks later. The medical examiner's report indicated an autopsy was performed and the cause of death was cardiac valvular disease. The same report indicated an injury did not contribute to the resident's cause of death.

During an interview, the nurse stated the resident's service plan was reviewed after each fall and updated with new interventions as needed.

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 is deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Care was coordinated with the hospice provider and the primary medical provider. The resident's plan of care was reviewed and updated.

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
	27398	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

(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 February 11, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL273982600C /#HL273985382M. No correction orders are issued.	0 000		