Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL290042062M
Compliance #: HL290043549C

Date Concluded: June 13, 2025

Name, Address, and County of Licensee Investigated:
The Shores of Lake Phalen
1870 East Shore Drive
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Holly German, 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 they failed to assess the resident after a change in condition, resulting in additional falls and injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility staff assessed the resident after falls, notified the provider and family, provided medical care as necessary. The facility assessed the resident for change in condition upon her return from the hospital.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, staff schedules and related facility policy and procedures. Also, the investigator observed resident cares while on site.

The resident resided in an assisted living memory care unit. The resident's diagnoses included unspecified dementia and long-term use of anticoagulants. The resident's service plan included assistance with toileting safety monitoring. The resident's assessment indicated she could understand others and could make her needs know. The assessment prior to having falls indicated the resident was independent with transfers and used a walker.

A facility incident report indicated the resident had a fall in her room, while returning to her bed from the bathroom. The resident sustained a bruise to her left knee and had no immediate complaints of pain. The same report indicated the resident had an additional fall approximately seven hours later in her room, and the resident was not sure how she fell. The resident complained of hip pain while bearing weight. The resident was transported to the emergency room. The report included staff action of removing the resident's walker from her view to avoid temptation of self-transfers, and directive for the resident to wear shoes, not just socks.

The resident's progress notes indicated the resident was admitted to the hospital with a pelvic and a lumbar (back) fracture. The notes indicated the resident returned to the facility the next day with new orders for medications.

A facility incident report completed the day the resident returned from the hospital, indicated the resident was found on the floor in her room by staff with blood coming from her head and a cut on her elbow. The report indicated the resident had two falls on this date that were approximately four hours apart. At the time of the second fall on this date, the resident was noted to be on the floor in her kitchen with no walker or wheelchair with her. The report indicated the nurse was called, followed by a call to 911 for transportation to the emergency room. The report indicated the plan for the resident upon return to the facility was hospice services and to initiate the use of a broda wheelchair and a hospital bed.

The resident's progress notes indicated the resident was re-admitted to the hospital for a second pelvic fracture. The notes indicated the resident returned to the facility four days later and began hospice services the next day. The notes indicated the resident's services were updated upon her return for her change in condition, and she required the assistance of two staff with a mechanical lift for transfers.

A nursing assessment performed after the resident returned from the hospital indicated a change to the resident's transfer and mobility abilities, requiring full assist from staff. The resident's service plan was updated to reflect the change in needs with transfers indicated the resident required hourly safety checks.

While on site, the investigator noted multiple signs hung in the resident's room to remind her to have staff assistance. The investigator also noted a safety mat on the floor next to the resident's bed while she was in bed.

During an interview, unlicensed personnel (ULP)-1 stated when a resident had a fall, the staff have a meeting to go over any changes to the resident's plan of care.

During an interview, ULP-2 stated staff can see changes or directions for fall preventions in the resident's care plan or behavior care plan.

During an interview, a nurse stated interventions were documented on incident reports and the resident's service plan where the ULP sign off on the cares or interventions for fall prevention. The nurse stated a note was placed in the resident's medication administration record (MAR) for the ULP to be notified of any changes or new needs the resident has for fall prevention. The nurse stated staff check in on a resident for three days after a fall. The nurse stated the resident had a cognitive decline overtime and moved on to the memory care unit where she did most of her activities of daily living on her own. The nurse stated the resident became impulsive and had trouble understanding what she could no longer do on her own. The nurse stated after the resident fell, she was admitted to the hospital and returned to the facility, she had a back brace to be worn when out of bed. The nurse stated she requested therapy orders to work with the resident and get more ideas on what could be done to help the resident at her cognitive level. The nurse stated the resident fell again in a short amount of time before they had the chance to initiate new fall prevention interventions. The nurse stated the resident returned from the hospital with orders for hospice services, a hospital bed, and a broda wheelchair to help keep her safe.

During an interview, the resident did not recall having any falls and denied having any concerns about the care she received at the facility. The resident stated staff come quickly when she uses her call button for assistance.

During an interview, a family member stated she believed the staff were caring for the resident how they were supposed to, and felt the falls the resident had were due to the resident not realizing her declined abilities. The family member stated she had no concerns about the care the resident received at the facility.

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.
(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided medical care as required and provided the needed care with the resident’s change in condition.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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
	29004	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF LAKE PHALEN	1870 EAST SHORE DRIVE 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 ******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: HL290043550C/HL290042063M HL290043549C/HL290042062M On June 2, 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 72 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL290043550C/HL290042063M and HL290043549C/HL290042062M, tag identification 730.	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.	
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to document personalized fall prevention interventions, as required for 2 of 2 residents (R1, R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's diagnosis included stroke and congestive heart failure. R1's service plan dated May 2, 2025, indicated R1 received assistance with transfers, bathing, toileting, dressing, and medication administration. R1's assessment dated November 1, 2024, indicated R1 was at risk for falling, but lacked documentation of any fall prevention interventions. R1's incident report dated April 9, 2025, at 3:13 p.m., lacked documentation of any fall prevention	0 730	Assisted Living Provider 144G. 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.	

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0 730	Continued From page 3 interventions initiated after a fall. R1's incident report dated April 13, 2025, at 2:20 p.m., lacked documentation of any fall prevention interventions initiated after a fall. R1's incident report dated April 14, 2025, at 1:00 p.m., lacked documentation of any fall prevention interventions initiated after a fall. R1's post falls progress notes dated April 10, 2025 through April 16, 2025, lacked any documentation of fall interventions initiated after falls. R1's individual abuse prevention plan (IAPP) dated May 8, 2025, lacked any documentation of fall prevention interventions. R1's medical records lacked a care plan or behavior care plan that indicated fall interventions. R1's medication administration records (MARs) dated April 2025 and May 2025, lacked any orders to complete or monitor fall prevention interventions. On June 3, 2025, an email from registered nurse (RN)-E to the investigator included photographs of fall interventions including painting the call pendant that needs to be pressed a darker color, a sign directing staff to move R1's bedside table close to the bed when R1 was in bed and a sign to remind R1 not to self-transfer and call staff for help. R2's diagnosis included dementia and falls. R2's service plan dated May 2, 2025, indicated R2 received assistance with transfers, bathing,	0 730	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.	

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0 730	Continued From page 4 toileting, dressing and medication administration. R1's service plan dated May 2, 2025, lacked documentation on any personalized fall prevention interventions. R2's incident report dated April 8, 2025, indicated R2 had a fall. The report indicated staff were to remove R2's walker from R2's view by hiding it in her closet, and indicated R2 was to wear shoes and not just socks. R2's change in condition assessment dated April 15, 2025, lacked documentation on R2's need to use a back brace when out of bed. The assessment lacked documentation of any fall prevention interventions, including the interventions identified in the incident report. R2's medical record lacked documentation on directive for the caregivers to be aware of and complete fall interventions. While onsite on June 2, 2025, at 11:21 a.m., the investigator noted signs hung in R2's room reminding R2 to use the call pendant and wait for help. The investigator noted a blue safety matt on the floor next to R2's bed while R2 was in bed. During an interview on June 2, 2025, at 11:00 a.m., unlicensed personnel (ULP)-A stated there was a staff meeting to go over changes after a resident fell. During an interview on June 2, 2025, at 11:05 a.m., ULP-B stated changes to resident cares or fall interventions were stated in the resident's plan of care or behavior plan of care. During an interview on June 5, 2025, at 11:00	0 730		

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0 730	Continued From page 5 a.m., registered nurse (RN)-E stated fall interventions were added on to the incident report and to the service plan where ULP sign off on cares, along with a note in the MAR so ULP see it. RN-E stated ULP would sign off on the fall prevention interventions. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		