Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL299536744M
Compliance #: HL299532706C

Date Concluded: October 30, 2023

Name, Address, and County of Licensee Investigated:
Dellwood Gardens
753 7th Street East
St. Paul, MN 55106
Ramsey County

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

Evaluator's Name: Brandon Martfeld, 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):
An unknown staff member neglected a resident after the resident fell. The resident sustained a bruised face, and right arm and neck pain after the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. During the investigation, an alleged preparator (AP) was identified, and the AP was responsible for the maltreatment. The AP assisted the resident off the floor following a fall and failed to notify the nurse following the fall. After approximately 10 hours the nurse became aware of the fall and arranged for the resident to be evaluated at a hospital. The resident was diagnosed with a fractured neck and a fractured right arm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident and the resident's family members. The investigator attempted multiple times to contact the AP. The

investigation included review of the resident's medical record, AP personnel record, facility investigation, hospital records and policies and procedures. Also, the investigator completed a facility tour.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes with neuropathy (numbness of both hands and feet), fibromyalgia (widespread musculoskeletal pain), and tremors. The resident's assessment indicated the resident was independent with transfers and walking. The resident's service plan indicated the resident used a four wheeled walker independently within the apartment and was alert and oriented.

The facility's progress notes indicated one morning when dispensing medications to the resident, unlicensed personnel discovered a bruise on the resident's forehead and a bloody big toe. The resident stated the previous night when she stood to go to the bathroom, the resident's legs became weak, and she fell. The resident was complaining of right arm and neck pain and the resident was sent to the hospital.

The facility investigation indicated one mid-morning., the day shift unlicensed personnel (ULP) observed the resident with a large bruise to her forehead, blood on the floor and a missing toenail. The resident reported during the night, she fell, pressed her call pendant and two staff assisted her off the floor. The resident reported neck pain to the ULP, and the nurse arranged for the resident to be evaluated at a hospital. During the facility investigation, it was determined the resident fell on the overnight shift, and the AP did not report the fall to the nurse.

During an interview, the resident stated she fell forward out of her recliner chair and landed on her forehead.

During an interview, the day shift ULP stated the resident was complaining of toe and neck pain. The resident stated she fell during the night and overnight staff assisted her off the floor. The ULP stated there was no report from the AP of the resident's fall. The ULP stated new employees were educated during orientation that when a resident falls, the nurse must be notified.

During an interview, another ULP stated she worked at another area of the facility during the night shift when the AP contacted her to assist getting the resident up from the floor. The ULP stated she assisted the AP getting the resident off the floor and returned to her assigned area. The ULP stated, the AP was responsible for the resident's care and to notify the nurse of the resident's fall.

During an interview, the nurse stated she was notified by the day shift ULP of the resident's fall the previous night. The nurse stated when entering the room, the resident had a bruise to her forehead and a bleeding toe. The nurse stated the resident complained of neck and arm pain. The nurse stated she arranged for the resident to be evaluated at a hospital. The nurse stated

following a resident fall, staff were educated to notify a nurse of the fall. The nurse stated the AP failed to notify the nurse of the resident's fall.

During an interview, facility leadership stated they reviewed the call pendent log from the previous night and determined the resident fell and pressed the call pendent at 12:30 a.m. The next morning around 10:30 a.m., the day shift ULP entered the room and the resident complained of toe and neck pain. During the facility investigation, it was determined the AP worked the overnight shift and was responsible for the resident. The AP did not notify the nurse of the resident's fall. Facility leadership stated when they interviewed the AP, the AP stated she forgot to notify the nurse of the resident's fall. The facility leadership stated cares for the resident were delayed because the nurse was not updated.

Hospital records indicated the resident sustained a fractured neck and although the resident had a previous fracture in her right arm, the fall refractured the right arm.

The AP's personnel file indicated the AP was educated about reportable events and contacting the nurse.

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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
The resident was sent to the hospital for evaluation. A facility investigation was completed, and the AP is no longer employed by 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.

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
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29953	A. BUILDING: _____ B. WING _____	C 09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLWOOD GARDENS	753 EAST 7TH STREET SAINT PAUL, MN 55106

(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: HL299536744M / HL299532706C On September 5, 2023, 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 77 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL299536744M / HL299532706C, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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.	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29953	A. BUILDING: _____ B. WING _____	C 09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLWOOD GARDENS	753 EAST 7TH STREET SAINT PAUL, MN 55106

(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 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		