Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306839366M
Compliance #: HL306837036C

Date Concluded: January 9, 2024

Name, Address, and County of Licensee Investigated:
Brookdale of Eagan
1365 Crest Ridge Lane
Eagan, MN 55123
Dakota County

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

Evaluator's Name: Lori Pokela, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 unlicensed personnel/alleged perpetrator (AP) abused the resident when they restrained the resident by pushing the resident up against a table, locked the wheelchair brakes and restricted the resident's movement.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the unlicensed personnel/alleged perpetrator (AP) acknowledged locking the resident's wheelchair brakes on one occasion, the actions of the AP did not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospice agency staff. The investigation included review of medical records and facility policies and procedures. At the time of the onsite visit, the investigator observed medication administration, resident cares, and staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease. The resident's service plan included assistance with dressing, bathing, toileting, medication management, and escort assistance to the dining room and activities. The resident's assessment identified cognitive and physical deficits, a history of falls, and the resident required staff assistance and a walker for mobility. The assessment did not identify the type of wheelchair the resident utilized or if the resident could independently utilize the wheelchair brakes. The resident's medical record indicated around the time of the incident, hospice services were initiated due to the resident's mental and physical decline.

Facility internal investigation documentation indicated a hospice staff member found the resident alone at a dining room table, in a reclining-type wheelchair. The wheelchair brakes were locked, and the resident was pushed up close to the table against the dining room wall. The resident was fidgeting and trying to push himself away from the table. The hospice staff assisted the resident away from the table to visit and later returned the resident to the dining room. Upon return, a staff member/AP told hospice staff to bring the resident back to the table and lock the wheelchair brakes. The hospice staff member only placed one of the wheelchair locks on and ensured the resident was not alone before she left the facility.

Facility nursing staff interviewed could not recall what type of wheelchair the resident used at the time of the incident but indicated the resident did not use a reclining-type wheelchair due to a history of falls. Facility nursing staff stated the resident received hospice services at the time of the incident for a variety of reasons including weakness, recurrent falls, and an increase in behaviors. Nursing staff also recalled the resident's ability to utilize his wheelchair brakes was inconsistent and varied from day to day due to his health decline.

During an interview, the AP indicated the day of the incident she was concerned about the resident's frequent self-transfer attempts, so she locked the brakes on the wheelchair to ensure the resident's safety. The AP acknowledged she told hospice staff to bring the resident back to the table and lock the wheelchair brakes to continue to keep the resident safe but could not recall if hospice followed her request. The AP denied abusing or restraining the resident and indicated she was re-trained following the incident.

Facility administrative staff interviewed indicated there was no evidence of harm to the resident and all staff were retrained on appropriate wheelchair brake use, fall interventions, and the use of restraints following the incident.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No; Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed an internal investigation, retrained the AP, and completed re-education with all facility staff.

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
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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: #HL306837036C/#HL306839366M On December 11, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 32 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306837036C/#HL306839366M, tag identification 1620.	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.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed staff conducted resident monitoring and review based on changes with resident needs for one of four residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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 an isolated scope (when one or a limited number of residents are affected or one or	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 2 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's assessment record did not accurately depict the current status of R1's behaviors, mobility, and level of staff assistance required at the time of an incident occurring on October 16, 2023. R1's diagnoses included, Alzheimer's Disease, chronic kidney disease, peripheral vertigo, and anemia. R1's most current service plan utilized on October 16, 2023, dated July 6, 2023, and signed by registered nurse (RN)-B, indicated R1 was receiving escort and mobility assistance as needed,(PRN), and did not receive behavior management services. R1's medication administration record (MAR) for July 2023 included: -Citalopram 0.5 milligrams (mg) capsule, by mouth, (PO) every day, (QD) for anxiety with a start date of July 6, 2023. R1's most current Individual Abuse Prevention Plan, (IAPP), utilized on October 16, 2023, dated July 6, 2023, and signed by RN-B, indicated R1 had a history of falls, R1 also utilized a walker with staff assistance. The IAPP indicated R1 did not have behaviors at the time of the assessment. R1's progress notes dated July 28, 2023, at 8:53 a.m., signed by RN-B, indicated R1's new wheelchair was delivered to the licensee.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 3 R1's progress notes dated July 31, 2023 at 9:30 a.m., signed by RN-B, indicated R1's family requested an order for occupational therapy (OT), as they believed R1 would benefit from OT showing R1 how to use the wheelchair. R1's most current nursing assessment utilized on October 16, 2023, dated July 31, 2023, and signed by RN-B, indicated R1 was received staff assistance with activities of daily living, (ADL's), including medication management and toileting. The nursing assessment indicated R1 had cognitive deficits, physical deficits, a history of falls, used a walker for mobility, and needed staff assistance to get to destinations. The assessment further indicated R1 did not exhibit behaviors at the time of the assessment. R1's care plan utilized October 16, 2023, dated July 31, 2023, indicated R1 needed staff assistance to stand for cares, however, used a walker for mobility purposes. Review of R1's August 2023 MAR reflected the use of additional medications when compared to R1's July 2023 MAR. R1's MAR for August 2023 identified the following prescribed medications: Gabapentin 100 mg capsule, as needed, (PRN) for anxiety and restlessness. (start date: August 26, 2023) Duloxetine HCL 60 mg capsule, PO, QD, for generalized anxiety disorder. (start date: August 27, 2023) Trazodone HCL 50 mg tablet, PO, PRN, twice a day, (BID) for behaviors. (start date:	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 4 August 27, 2023) Seroquel 12.5 mg tablet, PO, BID for anxiety and agitation. (start date: August 29, 2023) R1's August 2023 MAR reflected the use of medications to treat anxiety, agitation, restlessness and other behaviors. However, R1's assessment, service plan, and IAPP were not updated to reflect the identified behaviors, use of medications for behavior management, or monitoring of identified behaviors. R1's progress notes dated August 14, 2023, at 4:40 p.m., indicated R1 was self-transferring to his wheelchair and fell. R1's progress notes dated August 26, 2023, at 12:45 p.m., indicated R1 got into his wheelchair and mumbled after a fall. R1's progress notes dated August 31, 2023, at 3:40 p.m., indicated R1 scooted himself towards another resident in an aggressive manner. R1's progress notes dated September 18, 2023, at 4:10 p.m., indicated R1 stated he was reaching for his wheelchair and fell. R1's progress notes dated September 30, 2023, at 5:50 a.m., indicated R1 was found on the floor next to his wheelchair. R1's progress notes dated October 2, 2023, at 10:28 a.m., indicate R1 attempted to stand from his bed using the wheelchair and lost his balance. R1's communication note dated October 2, 2023, signed by R1's physical therapist, indicated R1	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 5 worked on leg exercises and wheelchair mobility, but was tired during the visit. R1's progress notes dated October 5, 2023, at 3:00 p.m., indicated R1 was sleeping in his wheelchair. R1's progress notes dated October 6, 2023, at 12:27 p.m., indicated R1 sat in his wheelchair, leaned forward and fell out. R1's hospice medical records indicated R1 was admitted to hospice services on October 13, 2023. R1's MAR for October 1, 2023 through October 13, 2023, indicated R1 was prescribed and administered the following medications: -Duloxetine HCL 60 mg capsule, PO, QD, for anxiety. (start date: October 3, 2023) -Seroquel tablet 12.5 mg PO, BID for anxiety and agitation. (start date: October 3, 2023) -Lorazepam tablet 0.5mg, PO, every four hours (Q4H), PRN, for agitation and anxiety. (start date: October 11, 2023) administered on the following dates for agitation and anxiety: R1's MAR documentation also identified the following: -October 11, 2023 at 12:19 p.m., indicated R1's administration of Lorazepam was ineffective. -October 12, 2023 at 12:37 a.m., indicated R1's administration of Lorazepam was effective and given when R 1 attempted to get up and walk while shouting.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 6 -October 13, 2023 at 12:36 p.m., indicated R1's administration of Lorazepam, which was given for agitation was ineffective. R1's October MAR also identified the use of medications for behavior management, however R1's assessment, service plan, and IAPP did not identify R1 to exhibit behaviors, monitoring of behaviors, or the use of medications to manage behaviors. R1's fall reports from October 1, 2023 to October 13, 2023, indicated R1 sustained six falls, two of which involved R1's wheelchair. R1's service delivery records for October 1-26, 2023, indicated R1 used a walker or wheelchair, required staff assistance with escorts, mobility, and the use of a gait belt. This service delivery record lacked documentation of how R1 transferred and lacked documentation regarding monitoring of R1's behavior. R1's nursing assessment was updated on October 20, 2023, signed by RN-B, and indicated R1 required the use of a mechanical lift for all transfers,was non-compliant with cares and physically aggressive toward staff. The assessment further indicated R1 utilized a walker for mobility and lacked documentation regarding the use of a wheelchair. A licensee investigation dated November 1, 2023, signed by the licensed assisted living director, (LALD)-A, identified an incident occurred on October 16, 2023, R1 was pushed up to a table in his wheelchair with the wheelchair brakes in the locked position.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 7 During an interview on December 11, 2023 at 2:22 p.m., RN-B stated R1 was admitted to hospice for several reasons including behaviors, weakness, and decline. RN-B stated R1 displayed behaviors since R1's admission to the licensee. RN-B also stated R1 did not use a recliner-type chair like a Broda Chair, because of his history of attempts to get out of his wheelchair. Instead, a standard wheelchair was used with anti-roll back equipment. RN-B stated R1's walker remained on all nursing assessments because family had hoped he would be able to use the device. During an interview dated December 11, 2023, at 3:05 p.m., unlicensed personnel, (ULP)-C stated R1 was in a reclining-type Broda chair and required the use of a mechanical lift for all transfers at the time of the incident on October 16, 2023. ULP-C also stated prior to R1 using the reclining-type chair, R1 utilized a standard wheelchair with anti-roll brakes. ULP-C stated R1 did not use his walker for mobility, only to help balance during transfers from one surface to the next. ULP-C stated R1's behaviors escalated around September 2023, when R1 would get verbally and physically aggressive with staff. During an interview dated December 13, 2023, at 9:03 a.m., R1's hospice chaplain, (ADM)-D, stated R1 was in a reclining-type chair at the time of the incident on October 16, 2023, when ADM-D was visiting with R1 in the licensee's dining room around lunchtime. ADM-D also stated R1's mechanical lift sling was on the table in front of R1 until a staff member picked up the sling from the table as the staff then asked ADM-D if she had taken the sling out from under R1. During an interview dated December 13, 2023, at	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 8 11:06 a.m., a family member, (FM)-E of R1 stated R1 began using a reclining-type Broda chair and mechanical lift shortly before admitting to hospice services. FM-E stated R1 was not always compliant with using the mechanical lift but did not use a walker in the month of October 2023. During an interview dated December 14, 2023 at 9:03 a.m., R1's family member, (FM)-F stated R1 was using a standard wheelchair on October 16, 2023, for mobility and began using a mechanical lift for transfers on October 9th or 10th 2023. FM-F also stated R1 did not use his walker since his admission to the licensee, instead he used a standard wheelchair until the family could purchase one. FM-F stated R1 used a reclining-type Broda chair after his admission to hospice on October 13, 2023. FM-F recalled the facility notifying her of R1's behaviors in September 2023. During an interview on December 14,2023 at 3:36 p.m., R1's hospice nursing staff stated R1 utilized a mechanical lift for all transfers and a reclining-type wheelchair beginning on October 16, 2023. The licensee provided Change in Condition Policy, dated February 2021, indicated a change in condition should be evaluated and documented for resident who exhibits significant deviation in physical or mental status such as: change in medical condition, change in behavior or change in cognition. The policy also indicated the resident's service plan should be updated as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01620	Continued From page 9 (21) days	01620		