Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306845701M
Compliance #: HL306847981C

Date Concluded: February 20, 2025

Name, Address, and County of Licensee Investigated:
Brookdale West St. Paul Memory Care
315 Thompson Ave E.
West Saint Paul, MN 55118
Dakota County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, facility 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):
The facility neglected a resident when facility staff failed to assess and develop interventions following the resident falls. In addition, facility staff failed to provide services for the resident according to resident's care plan including escorts to meals, oral care, responding timely to the resident's call light, and maintaining a clean environment for the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess, provide interventions, and notify the resident's provider following the resident's multiple falls in order to prevent future falls and injuries.

It was inconclusive whether staff failed to provide the resident with her care planned needs due to conflicting information provided by facility staff and family.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice care. The investigation included review of employee and resident records, facility policies and procedures. Also, the investigator observed medication administration, resident cares, and meal services.

The resident resided in an assisted living memory care unit and received contracted hospice services. The resident's diagnoses included dementia and chronic pain. The resident's service plan included assistance with medication management, dressing and grooming, bathing and incontinence assistance, escorts to meals, mobility assistance, and safety checks. The resident's assessment indicated the resident was a vulnerable adult and staff were to ensure the resident's safety and report any suspected abuse. At the end of her decline, the resident was unable to utilize the call light.

Hospice service plan included assisting the resident with medications, chronic condition management, bathing and skin care.

The resident record indicated over a period of one month, the resident fell three times when attempting to self-transfer causing multiple bruising. While staff stated the resident fell frequently, staff did not document every time the resident fell. The facility failed to provide updated assessments or develop interventions following the falls to prevent future falls and injuries.

Photos provided show bruises in various stages of healing on the resident's left knee, right ear, right side of neck, and right thigh.

Record review indicated the bruising was caused by the resident's multiple falls.

The hospice record indicated hospice staff assisted facility staff with the resident to complete activities of daily living including showers and baths along with grooming. Hospice staff indicated they also planned on providing the resident with nail care. The record indicated the resident had an unintentional weight loss due to her medical diagnoses.

During an interview, unlicensed personnel stated there should always be two staff members on memory care, but they often worked with just one staff member. The unlicensed staff stated the resident had frequent falls however staff often did not complete the required documentation of the falls. The unlicensed staff stated he came in one day and found the resident on the floor and did not know how long she had been there. The unlicensed staff stated he followed the falls protocol, and the resident was not harmed.

During an interview, another unlicensed personnel stated the resident preferred not to leave her room for meals and preferred snacks in her room that were provided by staff and family. The resident preferred to only eat an evening meal in the main dining room.

During an interview, the director of nursing (DON) stated she was out of the facility during the resident's stay at the facility and did not provide any cares to the resident. DON stated there should always be two staff members working in memory care, and was aware the unit needed a manager and additional direct care staff, and they were working on that. DON stated all staff were trained on the falls policy and should complete the form before the end of the shift, but that did not always happen

During an interview, a family member (FM) stated a staff member reported to her the resident had fallen frequently during the last month at the facility. FM stated the resident was missing meals because she would not come out of her room on her own and staff would not get her and bring her to the dining room.

In addition, other concerns investigated included the resident's call light not being answered in a timely manner, the room being dirty, the toilet not cleaned, and the resident's toenails were not clipped. The call light report did not provide insight into call usage and the resident was unable to use the call light in the last days of her decline in health. During a tour of the facility, there were no concerns with the cleanliness of the facility and although a photograph of the resident's toenails indicated they had not been clipped for several months, both facility staff and hospice staff were responsible to assist with clipping the resident's toenails. There was a concern regarding oral care and dentures not being cleaned, however, the resident's service plan indicated staff completed this task. Another concern indicated the staff gave the resident morphine 45 minutes late. While documentation showed morphine was provided 45 minutes late, facility policy indicated medications can be given an hour before or an hour after the scheduled time.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility is working on hiring managers and direct care staff.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Dakota County Attorney
West St. Paul City Attorney
West Saint Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30684	A. BUILDING: _____ B. WING _____	C 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL MC	315 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118

(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****** HOME CARE PROVIDER/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: #HL306847981C/#HL306845701M On October 21, 2024, 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 20 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL306847981C/#HL306845701M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. 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 the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		