Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362526083M
Compliance #: HL362524420C

Date Concluded: December 2, 2025

Name, Address, and County of Licensee Investigated:
The Pillars of Prospect Park
22 Malcom Avenue Southeast
Minneapolis, MN, 55414
Hennepin County

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

Evaluator's Name: Angela Vatalaro, 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 facility staff failed to provide adequate supervision. As a result, the resident barricaded himself in the bathroom drank shampoo and hand soap in attempts to harm himself. The resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a history of suicidal ideation, and the facility had interventions in place. The day the resident admitted to the memory care unit; the resident barricaded himself in his bathroom. The resident told staff he drank shampoo and hand soap in attempts to harm himself. During the shift prior to the incident, the resident did not verbalize any suicidal ideation. In addition, the resident did not have history of drinking shampoo or hand soap in attempts to self-harm. The facility staff called EMS (emergency medical services) and the resident transferred to the hospital.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of the resident's records, hospital records, facility incident reports, and related facility policy and procedures. Also, the investigator observed the memory care unit and staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, mild cognitive impairment, and depression. The resident's service plan included assistance with behavior management of suicidal ideation and safety checks during shift. The resident's assessment indicated the resident was oriented to person, with short term memory impairment. The resident ignored his own safety, had previously drank a bottle of whiskey, and had previously written a suicide note. The interventions in memory care included to keep apartment door open, items such as belts, scarves, cords, sharp objects, silverware, were removed from the room. Lotions and creams were locked in medicine cabinet. The resident was to eat in dining room and staff were to conduct safety checks. The resident walked independently using a walker requiring cues, reminders, stand by assist. The resident also had a pending evaluation for hospice services.

Records indicated the resident had a change in condition while residing in the assisting living setting. The resident's changes included increased agitation, aggressiveness, refusals of care, and the resident started to wander unsafely. An outside agency added services which included a companion for the resident 12 hours a day. In the assisted living setting, staff found a handwritten "suicidal note." Staff called the nurse, EMS, as well as the crisis team. The resident transported to the hospital, was seen for passive suicidal ideation (suicidal thoughts), and discharged back to the facility. The resident's records also indicated during the timeframe of these changes in the assisted living setting, the facility added interventions including putting the resident on a list for memory care placement for increased supervision and additional support. While the resident resided in the assisted living setting, the facility updated the resident's medical provider of changes, and the resident was also seen by his medical provider.

One day while the resident still resided in the assisted living setting, staff found the resident on the bathroom floor on his stomach, passed out next to a bottle of alcohol/liquor. Staff contacted EMS and the resident transported to the hospital.

The resident's hospital records indicated the resident was admitted. The resident hospitalized for four days, was evaluated by psychiatry, and discharged back to the facility. The records indicated when discharged, the resident would admit to the memory care setting. The resident discharged back to the facility in stable condition with medication changes.

On the same day the resident admitted into the memory care unit, an incident report indicated the resident barricaded himself in the bathroom, locked the bathroom door, and had debris in front of the door attempting to block staff entrance. Unlicensed staff convinced the resident to open the door. The resident told staff he drank a half bottle of shampoo and the entire bottle of

hand soap. The unlicensed staff asked the resident why, the resident said he felt hopeless and wanted to harm himself. Staff called EMS and the resident transported to the hospital. Records indicated the resident hospitalized and did not return to the facility.

The resident's scheduled services record indicated the resident received safety checks.

The resident's records did not indicate any prior incidents of the resident drinking shampoo or hand soap in attempts to harm himself.

During an interview, unlicensed personnel (ULP) stated during shift prior to the incident, the resident did not verbalize any suicidal ideation. The ULP stated the resident had been doing well, interacted, ate a meal in dining, and was talkative with other residents. Later in the shift during a safety check, the resident was not observed in his bed. The resident was in the bathroom. The ULP stated he tried to open the door, and the resident barricaded it and pushed back on the door preventing it from opening. The ULP spoke to the resident through the door. The resident said he drank shampoo and hand soap. The ULP asked the resident why, the resident conveyed a message he was depressed and suicidal. The ULP talked the resident out of the bathroom. The resident was able to walk, and he had the resident sit on the bed. The ULP said he called a nurse, called EMS, alerted his co-workers, and removed the shampoo and soap bottles from the room. EMS sent mental health services. While awaiting their arrival, the ULP said he stayed near the resident's room door and himself, and other staff continued to check on the resident. Once mental health services arrived, mental health services conducted their assessment. The resident transferred to the hospital.

During an interview, nurse 1 stated the resident admitted to memory care from the hospital. Nurse 1 said prior to the resident's admission she proofed the resident's room for items that could be used to self-harm and medicated creams were locked up. Nurse 1 stated interventions were in place. Safety checks were increased, staff were instructed to keep the resident's door open at night, the resident had a call pendent, and the resident's room was located next to the communal dining area offering the ability for staff to see the resident more frequently. She instructed staff to keep close eyes on the resident. Upon admission, nurse 1 said she assessed and spoke to the resident. The resident appeared calm and was not agitated or anxious.

During an interview, nurse 2 stated the resident did not have prior history of drinking shampoo or hand soap in attempts to self-harm.

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

Action taken by facility:
When the resident expressed suicidal ideation, facility staff contacted EMS.

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
	36252	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(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 November 5, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL362524420C/#HL362526083M. No correction orders are issued.	0 000		