Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378697502M
Compliance #: HL378692901C

Date Concluded: February 28, 2025

Name, Address, and County of Licensee Investigated:
Broadwell Plymouth Senior Living
3025 Harbor Lane North
Plymouth, MN 55447
Hennepin County

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

Evaluator's Name:
Maerin Renee, 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):
The alleged perpetrator (AP) neglected the resident when the AP failed to notify a nurse after the resident fell and sustained an injury. This resulted in delayed care, as the resident was later hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. After the resident had a fall, the AP failed to call the nurse triage line. The AP did not report the resident had a bruise on her forehead, indicating a possible head injury. This resulted in a delay of care for the resident, who was later transported to the hospital and diagnosed with a stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family. The investigation included review of the resident records, hospital records, the facility internal investigation,

facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included aphasia (speech difficulty due to stroke) and hemiplegia/hemiparesis (one-sided paralysis due to stroke). The resident's services included assistance with activities of daily living, transfers, toileting, meals, and medication management. The resident's assessment indicated she was a fall risk and needed a one-person assist with most cares.

The facility's internal investigation indicated after the resident fell, the AP called the facility's attendance line to speak to a supervisor. The AP said he was doing midnight rounds when he found the resident on the floor in her room. The AP reported the resident had a small scrape on her right knee and she seemed fine. When asked, the AP did not report any other injuries. The supervisor instructed the AP to call the nurse triage line per protocol, because the supervisor was not a nurse. The AP said he would do that, but his tone sounded confused. The supervisor asked the AP if he had the nurse triage line phone number, and the AP said he did. The supervisor again instructed the AP to call the nurse triage line, and to call 911 if further concerns developed.

The AP's written statement indicated he called the attendance line and talked to a supervisor. The AP said he asked if he should call 911 but was instructed, instead, to call the family. The AP said he noted a scrape and a little mark on the resident's forehead. The AP said he continued to check on the resident until the morning.

A day shift caregiver called the supervisor to report the AP did not report the severity of the resident's fall. The day shift caregiver said there was blood on the resident's floor, the resident was refusing medications, not responding to him, and had a bruise on her forehead indicating a possible head injury. The morning caregiver said the scrape on the resident's knee was reported, but the AP said nothing about the bruise on her forehead or the blood on the carpet. The supervisor instructed the caregiver to call 911. EMS arrived and transported the resident to hospital.

A progress note written by a nurse six days after the resident's fall indicated the resident was found on her floor during a routine safety check. The resident was lying on her abdomen, and her right hand was under her abdomen. A bruise was noted on her forehead as well as an abrasion on her left knee. The resident was helped off the floor by the AP and another staff member and placed in her chair. The AP notified a supervisor. When day shift staff arrived, they noticed the resident was confused and disoriented. The triage nurse and a family member were notified, staff called 911, and EMS transported the resident to the hospital for further evaluation. At the hospital, the resident was diagnosed with a stroke.

The resident's abuse prevention plan indicated she had an unsteady gait and needed assistance with transfers due to one-sided weakness following a stroke. Her nursing assessment indicated

she had multiple strokes to the left hemisphere of her brain and needed moderate hands-on help with most activities. Safety checks were required two times per shift. She did not have any significant cognitive decline.

Hospital records indicated the resident had a history of previous strokes, and after her most recent fall she developed increasing confusion and difficulty speaking. Imaging revealed an acute stroke on the left side of her brain. The resident developed profound neurologic deficits and generalized weakness. It was unclear how long the resident had been on the floor, and she continued to experience right-sided weakness. Per physical therapy (PT), the resident presented with severe aphasia and required maximum assistance for mobility. Occupational therapy (OT) recommended admission to a post-acute rehabilitation facility and anticipated the resident would need a higher level of care than she had received at the facility.

The AP's training files indicated he received training in how to recognize a resident's change in condition, guidelines for when to notify a nurse/doctor, and falls protocols. Performance reviews indicated the AP had been counselled for missing mandatory meetings and sleeping on the job.

When interviewed a nurse said the resident required full assistance with cares due to one-sided weakness as the result of a stroke. After the resident fell, day shift staff who worked the next morning were very concerned when they saw the resident. The resident looked very confused and had a bruise on her forehead. The nurse read the incident report and saw the triage nurse had not been notified by the AP. The nurse also saw inconsistencies between what was reported and what was documented on the incident report. Neither the abrasion on the resident's knee nor the bruise on the resident's forehead were documented, nor was there mention of blood on the floor of the resident's room. The AP said he did not call the triage nurse because he had already talked to a supervisor, and he felt that was good enough. The AP said the resident did not look that bad to him.

When interviewed, a supervisor said she received a phone call around midnight from the AP saying he found the resident on the floor of her room, and he did not know what to do. The supervisor asked if the resident was injured, and the AP said the resident had a scrape on her knee and could move her leg. The supervisor asked if there were any other injuries and the AP said no, there were not. The supervisor instructed the AP to call the nurse triage line, because the supervisor was not a nurse, and protocol was to notify a nurse. The supervisor also instructed the AP to call 911 if he had further concerns about the resident. The supervisor asked the AP if he had the phone number to the nurse triage line and the AP said he did.

When interviewed, the AP said during rounds he found the resident on the floor of her room. The AP called a supervisor to report the fall and said the supervisor instructed him to call the family and the nurse triage line for further guidance. The AP said he could not find the nurse triage line number, nor did he request the number from the supervisor or another staff

member. The AP said he had previously called the nurse triage line number when he worked in memory care.

When interviewed, a family member said he received an unintelligible voicemail that night the resident fell, and then day staff called him again in the morning to let him know the resident fell. The family member did not know why help was not called earlier after the resident fell. He was disturbed by the bruise on the resident's forehead, which extended across her forehead, from eye to eye, and was about one inch wide. The family member felt the resident should have been taken to the hospital right away and maybe her injuries would not have been so bad. The family member did not believe the resident would ever recover from this stroke, and believed delayed care made her outcome worse.

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

Action taken by facility:
Facility leadership provided staff with refresher training regarding the falls protocol, including calling the nurse triage line for guidance, and calling 911 if there is a possible head injury.

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.

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

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
Hennepin County Attorney
Plymouth City Attorney
Plymouth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

(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: #HL378692901C/#HL378697502M On January 28, 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 105 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL378692901C/#HL378697502M, 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 an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		