Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204449205M
Compliance #: HL204446882C

Date Concluded: March 12, 2024

Name, Address, and County of Licensee Investigated:
Walker Methodist Care Suites
7400 York Avenue South
Edina, Minnesota 55435
Hennepin County

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

Evaluator's Name: Danyell Eccleston, 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 respond to the resident's pendant call for assistance. The resident fell on the floor and sustained a pelvic fracture and died three weeks later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to respond to the resident's call pendant and the resident self-ambulated and fell when walking back from the bathroom. The resident was diagnosed with a pelvic fracture.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and family members of the resident. The investigation included review of the resident record, death record, facility internal investigation, facility incident

report, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed staff providing care to residents.

The resident resided in an assisted living facility. The resident's diagnoses included history of spine fractures related to frailty of aging and weakness. The resident's service agreement indicated she received toileting assistance of one person and staff were to assist the resident to the toilet, physically assist the resident to use the toilet, and change undergarments and provide transfer assistance and cleaning private areas as needed. The resident's service plan included assistance with orientation and confusion, escorts with physical assistance or standby assistance to meals, pendant use reminders, safety checks related to fall risk, and taking the resident to the bathroom during scheduled toileting services. The resident's assessment indicated the resident needed to use a walker, had balance problems when walking, and had "some difficulty" using the call light system.

The facility investigation indicated staff found the resident lying on the bedroom floor with her walker near-by. The resident stated no one came to help her after she pressed her pendant call button and she walked on her own to use the bathroom and lost her balance and fell when she walked back to bed. Documentation indicated the resident had a safety check due approximately two hours prior to staff finding the resident on the floor, however, the safety check was not documented as complete by the AP until after the time of the fall. The investigation indicated the AP stated she did not think about calling another staff member for help when she had two residents who both needed assistance at the same time.

A handwritten statement from the nurse working during the time of the incident indicated the nurse attempted to contact the AP multiple times to let her know the resident's pendant call was active and not reset. When the nurse was on the way to the floor where the resident resided, the AP contacted the nurse via walkie-talkie and stated she found the resident lying on the floor. When the nurse questioned the AP why she did not answer her walkie-talkie when the nurse tried to call, the AP indicated her walkie-talkie was not working. The nurse then asked the AP how she was able to call him via walkie-talkie to notify him of the resident's fall and the AP did not respond to the question.

Review of handwritten statement from the AP indicated she was working with another resident when she noticed a light on in the resident's room. The AP indicated, approximately 45 minutes before the resident's pendant call was reset, she found the resident in the bathroom and told the resident to wait for her to return. The AP indicated she left the resident alone in the bathroom, "because she was okay."

Progress notes from the day of the incident indicated the resident complained of right upper buttock pain after the fall. Approximately six hours after the resident was found on the floor, emergency medical services took the resident to the hospital due to increased pain, elevated blood pressure, vomiting, and the resident stating, "I can't walk, I fell today." The resident

returned to the facility two days later diagnosed with pelvic fractures, referral for hospice, and prescription for oxycodone (a narcotic pain medication).

Review of staffing records indicated the AP was the resident's assigned caregiver during the time of the incident.

The resident's pendant call report indicated during the time of the incident, the resident's pendant call was not reset for 49 minutes and 57 seconds.

Review of the resident's death record indicated complications of decreased mobility related to a fall that caused right pelvis fractures three weeks prior contributed to the resident's death.

The AP's employee file indicated the AP began employment at the facility approximately 14 months prior to the incident. The facility educated the AP regarding resident rights, falls prevention, standby assistance techniques, safe transfers and ambulation, incontinence assistance, and use of pagers and walkie-talkies. The AP met performance expectations for providing activities of daily living, personal care to residents, and using electronic devices including the walkie-talkie.

During interview, the AP stated she had a busy shift the day of the incident and was assisting another resident often during the shift. The AP stated the resident used her pendant call button and she helped the resident to the toilet and then left to assist another resident. The AP stated she heard a "boom" from the resident's apartment and walked in to find the resident on the floor of her room. The AP contacted the nurse and the AP and the nurse assisted the resident back to bed. The AP stated she approached another co-worker for assistance during the shift, but the co-worker was busy. The AP did not use her walkie-talkie to contact other staff members for assistance with residents when there were competing needs. The AP stated she did not reset the resident's pendant, which created a beeping sound and notification to her pager, because she did not know how to reset it.

During interview, multiple staff stated they would not leave the resident alone in the bathroom and would stay in the bathroom or within proximity to the resident until she was finished in the bathroom to ensure the resident's safety. The staff also stated they would contact other staff for assistance if they needed assistance with residents.

During interview, an unlicensed staff stated to reset a pendant call and stop pager notifications, staff need to physically see the resident to reset the button on the pendant and staff are directed to respond to a pendant call within five to seven minutes. The staff stated if an assigned staff cannot assist a resident in a timely manner, then the assigned staff member needs to call another staff person via walkie-talkie for assistance.

During interview, the resident's family member stated the resident reported staff did not come in to change her incontinent brief at the usual time and she was afraid of urine leaking on her

bed. The resident indicated when no one responded to the pendant call, she went to the bathroom alone. After the fall, the resident experienced a lot of pain and needed to be in a wheelchair.

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, vulnerable adult is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility implemented an additional process to monitor call lights. The AP is no longer employed at 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
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20444	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST CARE SUITES	7400 YORK AVENUE SOUTH EDINA, MN 55435

(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: HL204446882C/#HL204449205M On February 13, 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 63 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL204446882C/#HL204449205M, 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		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) 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	No plan of correction is required for this tag.	