Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215831001M
Compliance #: HL215838079C

Date Concluded: June 27, 2024

Name, Address, and County of Licensee Investigated:
Walker Methodist River Heights
744 19th Avenue North
South St. Paul, MN 55075
Dakota County

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

Evaluator's Name: Christine Bluhm, 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 Allegations:
The facility neglected the resident when facility staff members refused to provide medical assistance during a medical emergency. The facility called 911 but were not available to let first responders into the building and did not communicate with responders to assist the resident during the emergency.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Conflicting interviews indicated it was unclear whether the resident asked staff to leave her during the incident. It is possible there may have been a delay when staff members were not immediately available to let first responders into the locked facility but this possible delay did not result in neglect.

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

facility incident reports, staff schedules, the law enforcement report, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes and chronic pain and diagnosed after the incident with hospitalization with dyskinesia of the esophagus (spasms). The resident's service plan included assistance with laundry, light housekeeping, stand by bathing assistance and medication assistance. The resident's assessment indicated she was able to make independent decisions and direct her own care.

Review of the resident's progress notes indicated that one evening a staff member called the on-call nurse to report the resident was complaining of choking. The note indicated staff did not observe signs or symptoms of choking and the resident was communicating and breathing. Emergency responders arrived and transported the resident to the emergency room although the resident was alert and able to talk. The resident did admit to the hospital for blood pressure monitoring.

Review of the facility protocols indicated staff are to call the on-call nurse before calling 911 unless it is life threatening.

Review of the facility's Uniform Disclosure of Assisted Living Services and Amenities, (UDALSA), indicated unlicensed staff are not universally CPR certified but can call 911. The same document indicated that if a licensed nurse is available, that individual will perform CPR until relieved by paramedics.

During an interview, a manager stated it was evening at the time of the incident, there was not a licensed nurse in the building and unlicensed staff are not required to be trained in CPR. The manager stated that the incident was reviewed with managers the following morning in the daily stand-up meeting, was not made aware of any concerns, and believed staff responded appropriately in the situation.

During an interview, an unlicensed caregiver stated she checked to see if the resident and staff working in that area needed assistance after she saw the other staff member in and out of the resident's room. She said she returned to her duties because the resident was talking, and police were already there.

During an interview, the resident stated that she called 911 and police showed up first. She stated that a staff member also called 911 and other emergency personnel showed up. The resident stated that staff were there and called 911 for her, but she did not tell staff to leave at any time. The resident stated she was in the hospital with pneumonia after this incident and also diagnosed with an esophagus motility (swallowing) problem.

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: Yes.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility has provided additional training to staff members with a new process while carrying the phone that answers the locked entry doors.

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
	21583	A. BUILDING: _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST RIVER HEIGHTS	744 19TH AVENUE NORTH S ST PAUL, MN 55075

(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 June 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL215838079C/#HL215831001M. No correction orders are issued.	0 000		