Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL258293641M **Date Concluded:** October 14, 2024
Compliance #: HL258293987C

Name, Address, and County of Licensee Investigated:
The Alton Memory Care
1306 Alton Street
St. Paul, MN 55435
Ramsey County

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

Evaluator's Name: Michele Larson, 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 they failed to provide adequate monitoring and supervision according to the resident's assessed needs and service plan. As a result, the resident fell two times one night while unsupervised. In addition, the facility failed to maintain the resident's apartment at normal temperatures and as a result required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to provide the resident with his care planned every two-hour safety check and toileting assistance. The resident fell twice in one night and was on the floor for an unknown amount of time.

The Minnesota Department of Health determined neglect was not substantiated. It could not be determined if the resident's apartment heating issues contributed to the resident's hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed family members. The investigation included review of the resident record(s), in-house provider's records, death record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during her onsite visit.

The resident resided in an assisted living memory care facility and lived there for seven days until he was admitted to the hospital. The resident's diagnoses included Lewy body dementia, syncope (dizziness), impaired gait, and mobility. The resident's service plan included every two-hour safety check, reorientation checks, cueing, and toileting assistance several times during the day and overnight shifts. During the overnight shift, the resident required two-hour checks for frequent wandering. The resident had difficulty communicating but was able to make his needs known. The resident's assessment indicated he was at high risk for falls and required fall safety checks but only listed "clear path and proper footwear" as his fall reduction plan. The resident was moderately disoriented to person, place, or time and was unable to use the facility's call system.

The resident's progress note indicated late one evening., approximately 34 hours after the resident was admitted to the facility, the resident was found on the floor in a vacant apartment lying on his right side. The resident was assessed for injuries and assisted back to his apartment. It was unknown how long the resident laid on the floor before staff found him.

The resident's record indicated the resident fell again five hours later. The resident was found lying on a bathroom floor in another resident's apartment. The resident was unable to verbalize what happened. It was unknown how long the resident laid on the floor.

Review of the resident's service check-off list (services provided to the resident) indicated the resident did not receive any of his scheduled services including every two-hour safety check, frequent wandering checks, and toileting assistance.

Four days after the resident's falls, the resident was hospitalized with dehydration, atrial fibrillation, and high blood sugars. The resident spent four days in the hospital and was discharged to a rehabilitation center to regain his strength.

During an interview, a facility staff member stated the resident was frequently awake at night and required a lot of staff assistance. The staff member stated the majority of the time, the facility scheduled only two staff at night and the staff member recalled times when they were the only staff person working the overnight shift.

During an interview, another staff member stated services were sometimes not provided to the residents because there was not enough staff. The staff member stated sometimes staff would document the resident refused services instead of performing the services.

During an interview, a nurse stated the resident's family was concerned about the lack of staff and the resident's recent falls. The nurse stated they encouraged the resident's family to find another facility for the resident. The nurse stated the facility had no formal way of communicating stating there was little communication with staff.

During an interview, leadership stated the resident's family member moved the resident out of the facility because of concerns the facility was unable to meet the resident's needs. Leadership stated staffing levels were based on resident census, stating they met their minimum requirements of scheduling two staff during the overnight shift. Leadership stated they looked at a resident's "tendencies" for overnight staffing. Leadership stated the facility's acuity level was higher than a normal assisted living facility because it was all memory care.

During an interview, a family member stated the resident required supervision for most of his cares and stated she became alarmed when the resident fell twice in one night. The family member was concerned whether resident received enough supervision and questioned if the facility was able to meet the resident's need or keep him safe.

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. the resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility repaired the resident's apartment heat after the resident was sent to the hospital.

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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(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: #HL258293987C/#HL258293641M On August 29, 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 39 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL258293987C/#HL258293641M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

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02360	Continued From page 1	02360		
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. 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		