Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273985641M
Compliance #: HL273987910C

Date Concluded: October 31, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Seasons at Maplewood
1670 Legacy Parkway East
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Peggy Boeck, 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), a facility nurse, neglected a resident when the AP failed to assess, provide care for, or call emergency services when notified the resident had stroke-like symptoms. This delayed emergency medical treatment for seven hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. Although the AP received training as a registered nurse and received training on protocols for medical emergencies by the facility, the AP neglected to recognize the residents emergent change in condition and call 911 resulting in a delay of care.

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

reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living with diagnoses including a history of falls, heart disease, muscle weakness, and obesity. On admission the resident's service plan only included assistance with nail care and the resident was independent with all other needs (transfers, mobility, medication administration/ordering, bathing, grooming, and toileting). The resident's assessment completed after two fall incidents indicated the resident required additional services (assistance of two staff for transfers, dressing, and assistance of one staff for bathing, toileting, as well as safety checks up to three times per day).

An incident report indicated one morning around 9:00 a.m., a family member requested a nurse assess the resident as she appeared "unresponsive". The AP went into the resident's apartment 15 minutes later and soon left. A staff entered the apartment, saw the AP was gone, and the resident told her she felt "drunk, had a pounding headache, and felt confused."

During an interview, the staff stated she asked the AP for direction with the resident and the AP told her the resident "is fine, you can get her up" and that the resident's vital signs "are ok." The staff stated she and a peer got the resident dressed and up for the day. The staff stated she checked on the resident around 11:00 a.m., and the family member in the apartment stated the resident was still dizzy and confused. The staff reached out to another nurse, who asked the AP to do an assessment. The staff stated she heard the AP on the phone with another family member saying the resident was "having trouble speaking", but it was "not urgent, her vital signs are ok."

During an interview, a physical therapist stated she went to the resident's apartment for a scheduled physical therapy appointment at 2:00 p.m. The therapist stated she assessed the resident due to observed significant decline. The therapist stated she reported to the AP the resident was showing signs of a stroke (left sided weakness, slowed/slightly slurred speech, increased confusion, difficulty with details, inability to stand or reposition self, left lateral trunk lean and posturing with left closed fist and max wrist flexion) and should go to the hospital right away.

During an interview, a nurse manager stated a staff asked her, (two hours after the therapist assessment), when the ambulance was coming to pick up the resident. The manager stated no one told her until that moment that the resident had shown signs of a stroke "all day" and the AP had been in to "assess the resident" twice. The manager stated before she could go up to the resident's apartment, she saw the ambulance transport the resident out of the building (around 4:00 p.m.). The manager confirmed the protocol at the facility included the nurse calling 911 to provide clinical information.

During an interview, the AP stated although she had multiple years' experience as a nurse, she was still in orientation at the facility and felt overwhelmed with the amount of work assigned to

her on the day of the incident. The AP stated when asked to assess the resident, she obtained the resident's vital signs and asked the resident about pain. The AP stated she talked to the resident about going to the hospital, but the resident declined. The AP confirmed her documentation did not include any reference to "education" she provided to the resident to convince her to go to the hospital. The AP stated she called 911 right after documenting a progress note about her observation of the resident's signs of a stroke the second time she went into the resident's apartment.

The resident's progress note written by the AP at 10:24 a.m. indicated the AP took vital signs after a report of confusion and unresponsiveness. The progress note indicated the AP had "no concerns" about the resident and instructed staff to complete morning cares and get the resident up for the day.

The resident's progress note written by the AP at 2:48 p.m. indicated the resident was "noticed two hours ago to be having signs of stroke" including leaning to one side, total body weakness, couldn't do anything for herself, and slurred speech. The AP noted she was going to call EMS.

Hospital records indicated the ambulance arrived at the facility at 4:15 p.m. [of note the ambulance traveled from the hospital to the facility which was less than a mile] The hospital records indicated the resident had an ischemic stroke (a life-threatening condition caused by blood clots or other blockages in the brain). The hospital was unable to use medication to try to dissolve the blockage due to the length of time since first symptoms (must be given within three to four and a half hours of the first symptoms.) The hospital records indicated the resident remained hospitalized for seven days and transferred to a transitional care unit for rehabilitation.

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: Observed, but unable to interview.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by the facility. The facility filed a report with the Minnesota Board of Nursing.

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
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27398	A. BUILDING: _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

(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, this correction order is 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: #HL273987910C/#HL273985641M On October 17, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 131 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL273987910C/#HL273985641M, 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 wasresponsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	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.	