Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL299538266M
Compliance #: HL299535486C

Date Concluded: May 30, 2024

Name, Address, and County of Licensee Investigated:
Dellwood Gardens
753 East 7th Street
St. Paul MN, 55106
Ramsey County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Inconclusive

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 supervision. As a result, the resident overdosed on drugs and staff found him deceased.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility provided services to the resident as listed in his service plan, however they lacked updated nursing assessments. It is unknown if the completion of a nursing assessment would have identified the resident's substance use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident's records, hospital records, incident report, and death record. Also, the investigator toured the facility and observed staff administer

medications and treatments. The investigator observed the facilities computer documentation system.

The resident resided in an assisted living facility. The resident's diagnoses included a stroke and weakness to his left side, high blood pressure, and depression. The resident's service plan included assistance with mobility, bathing, dressing, toileting, meals, and medication administration. The resident's nursing assessment indicated his memory was intact, he could communicate his needs, used a phone and the call system without assistance. The nursing assessment indicated the resident used street drugs prior to admission into the facility.

Service delivery records indicated staff provided safety checks twice daily. There were no further safety checks or services scheduled during the night.

The resident's records indicated a nurse completed a nursing assessment fourteen days after he admitted into their facility, and his death occurred approximately eleven months later. There were no further nursing assessments, or changes in the services he received from the facility within those eleven months. However, the resident records indicated he required less staff support with mobility and personal cares after admission into the facility. The resident also began to drive again. The resident's service plan did not include updated service interventions, because there were no further nursing assessments completed.

During an interview, a manager said she saw the resident the afternoon prior to his death. The manager said she saw him sitting outside and talked with him as she left the building for the afternoon. The manager said she observed video footage from the time she last saw him to when staff found him deceased. The video footage showed a car arrived at the facility a few hours after she left and there appeared to be an interaction between the resident and someone else. The manger did not recognize the individual and the interaction was brief. The manager said there was another resident outside with him and both residents entered the building after the car left. The manager said video footage showed both residents went into each other's rooms throughout the evening. The manager gave the video footage to law enforcement. The manager said she had no concerns from staff or family about the resident using street drugs and there had been no prior instances of concern with him while he was at the facility. The manger said she spoke to the staff members who worked during the evening and night. There were no concerns about his behavior or appearance. The resident did not receive any services during the night. The manager said she spoke to the other resident who admitted they used street drugs; however, he did not provide any further information. After the incident, she asked law enforcement to talk with the residents and staff at the facility about street drugs, safety concerns, and treatment options for drug abuse. The manager said she also had meetings for staff how to identify suspicious activity, but in this instance, the resident did not act differently prior to his passing.

During an interview, a staff member said she saw the resident during the evening, and he appeared like his usual self. The staff member said the resident's behavior was normal and he

communicated his needs clearly. At the end of her evening shift, she was with him in his room. She said she tended to his laundry, made his bed, and left. There was nothing unusual about his behavior.

During an interview, a staff member said the resident did not require any services during nighttime. The staff member said they only complete safety checks on the resident's during the night if their service plan directs them to do so. The resident's service plan did not include nighttime safety checks.

During an interview, a staff member said they entered the resident's room to give him his morning medications and found him deceased. The staff member said there were street drugs on his table and dresser.

During investigative interviews, multiple staff members said they were shocked when they discovered the resident used street drugs at the time of his death because they had no concerns about him using street drugs before this incident.

During an interview, a family member said it was difficult for her to believe the resident died from street drug use because he was not an addict. The resident used street drug in the past, however nothing recent.

The medical examiner report indicated the resident died from street drug overdose.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility communicated with law enforcement and provided education and resources to the resident's and staff members.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29953	A. BUILDING: _____ B. WING _____	C 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLWOOD GARDENS	753 EAST 7TH STREET SAINT PAUL, MN 55106

(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 LICENSING CORRECTION ORDER(S) 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: #HL299535486C/#HL299538266M, #HL299538759C/#HL299531380M, #HL299539105C/#HL299531521M On April 16, 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 eighty-two residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL299535486C/#HL299538266M, #HL299539105C/#HL299531521M tag identification 1620. No correction orders were issued for #HL299538759C/#HL299531380M.	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.	

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01620	Continued From page 1	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conduct timely routine and change of condition assessments days for two of three residents (R1, R3) reviewed. The licensee's assessment process lacked identification of assessment due dates and person(s) responsible for completion of the assessments. As a result, this had the potential to affect all residents.	01620		

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01620	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee on October 11, 2022. R1's diagnoses included stroke, hemiplegia, hypertension, cardiomyopathy, post-traumatic stress disorder (PTSD), and psychoactive substance dependence. R1's nursing assessment dated October 24, 2022, indicated R1 tested positive for cocaine when evaluated for stroke at the hospital. R1 required assistance for transfers, ambulation, dressing, bathing, mobility, and toileting. R1's record lacked any further nursing assessments, including routine assessments due every 90 days. Progress notes dated September 2, 2023, indicated staff members found R1 deceased in his apartment. On April 17, 2024, at 10:12 a.m., surveyor requested licensed assisted living Director (LALD)-A to verify if R1's nursing assessment dated October 24, 2022, was the most recent nursing assessment licensee completed for him. Surveyor also requested LALD-A to provide most recent, full nursing assessment.	01620		

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01620	Continued From page 3 On April 17, 2024, at 1:31 p.m., LALD -A confirmed the licensee did not complete further nursing assessments for R1, and the assessment dated October 24, 2022, was his most recent nursing assessment. R3 admitted to licensee on March 16, 2020. R3's diagnoses included Alzheimer disease, chronic kidney disease, hypertension, glaucoma, asthma, irritable bowel syndrome, and arthritis. R3's nursing assessment dated November 21, 2023, indicated she had a change in her health condition due to recent hospitalization for hallucinations and confusion. R1 required antibiotic medications because of a urinary tract infection. The assessment indicated R3 required assistance with transfers, toileting, and bathing, but she was independent with dressing and grooming. R3 had mild cognitive impairment. R3's progress notes dated December 6, 2023, indicated R3 tested positive for Covid 19, and she started Paxlovid (anti-viral) medication. R3's cholesterol medication and inhaler required staff to not administer them while she received Paxlovid. On December 12, 2023, R3 appeared to be "washed out and weak" so nursing staff sent her to the hospital. R3's medical record lacked a nursing assessment to identify her change in condition on December 6, 2023. On April 18, 2024, at 10:08 a.m., RN-C said any nurse can complete resident assessments. RN-C said there was no system to alert the nurse if a resident required a 90-day assessment. RN-C said when a nurse completes an admission assessment, they place the subsequent	01620		

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01620	Continued From page 4 assessment due dates on a calendar and they would be responsible for completing further nursing assessments, but any nurse could complete them. When asked how nurses knew what assessments required completion in the absence of a nurse, RN-C said she could not answer. RN-C said she did not complete 90-day assessments because she did not focus on those assessments but would try to complete them. RN-C said she completed assessments when there were changes in the resident's health condition. On April 25, 2024, at 9:02 a.m., director of nursing (DON)-D said the computer system has a reports tab and when nurses click on it, there is a list of assessments required for completion. When asked how nurses know which assessments, they are responsible to complete, DON-D said the nurse on second floor is an LPN, so basically, it's her and RN-C who complete assessments. DON-D said the computer system generates assessment schedule based on when the last assessment was completed. DON- D said she completes assessments for residents who live on third floor and RN-C has been completing assessments for residents who live on fourth floor. DON- D said she has also started doing assessments for the residents who live on second floor. DON-D said prior to her becoming DON, she did assessments for residents who lived on third floor, and RN-C for the residents who lived on fourth floor. The former DON completed assessments for the residents who lived on second floor. DON-D said nurses were to complete nursing assessments for the floor they worked on. DON-D said, the nurses see all the residents on all floors, and manage their care. On April 26, 2024, at 1:22 p.m., former DON-B	01620		

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01620	Continued From page 5 said there was a system set up where staff were supposed to look at assessments and add them into the resident's services. DON-B said they had a calendar set up for things nurses needed to be complete. When asked how the nurses know which assessments, they were responsible to complete, DON-B said there is an assessment report you can look it up by assessments due, which is what we have been doing most of the time. DON-B said they tried to have nurses complete the assessments based on the floors at the facility. DON-B said if they had trouble getting to somebody, they would ask each other to help. Regarding R3, DON-B said she should have completed a nursing assessment to address her change in health condition when she tested positive for Covid 19. DON-B said she missed the assessment, but R3 did not require further services because she had services in place to address her health status. DON-B said she placed information for staff to direct care for R3 on the medication administration record (MAR). Licensee policy titled, 6.01 Assessments, Reviews, and Monitoring, dated February 4, 2024, indicated licensee would complete ongoing resident reassessments and monitoring as needed based on the changes in the reeds of the residents and would not exceed 90 calendar days from the date of the last assessment. Time period for correction: Seven (7) days	01620		