Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306293085M
Compliance #: HL306295078C

Date Concluded: January 6, 2023

Name, Address, and County of Licensee Investigated:
Walker Methodist Westwood I
1 Thompson Ave W
West St Paul MN 55118
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 abused the resident when the facility stated it could not meet her needs and forced her to move to another facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the resident required more assistance than the facility could provide in the unit she lived, the facility offered to transfer her to a different unit within the facility where her needs could be met. The resident and family declined this offer and the resident moved to a different facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted care coordinators and the hospice care providers and family members. The investigation included review of resident records, progress notes, facility polices, training records, internal incidents and facility records.

Also, the investigator observed staff and resident interactions, residents' rooms and accommodations, and facility operations.

The resident lived at the assisted living facility for several years. The resident's diagnoses included muscle weakness, back pain, and difficulty walking. The resident's medical record also indicated she had difficulty swallowing and required a specialized diet.

The resident's service plan indicated the resident required assistance of one staff member for bathing, transferring, and toileting. However, the resident's assessments indicated the resident needs increased slowly over several months and one staff member could no longer transfer her for tasks such as toileting, but rather required two staff members.

The resident's progress notes indicated the facility offered record indicated both the facility and the resident's family identified the residents growing need for additional help and support services. The same documents indicated the facility offered to transfer the resident to a setting which could provide a higher level of care along with physical and occupational therapy. The resident declined this offer, but instead the family and the resident opted to hire additional support to stay in the resident's apartment at the facility.

Over the next several months, the resident's progress notes indicated the resident continued to decline, eventually enrolled in hospice, and required assist of two staff members for transfer. The same documents indicated hospice helped coordinate a transfer to another facility which could provide a higher level of care.

During an interview, a family member acknowledged the resident was needing more care than when the resident was first admitted to the facility.

During an interview, the registered nurse stated the resident's condition declined over time and required more assistance than could be provided on the unit she lived. The registered nurse stated the facility offered to move her to another unit within the facility which could meet her needs, but the resident declined the offer. Eventually, the family moved the resident to a different facility.

During investigative interviews, multiple staff members stated as the resident declined it became very difficult for one person to provide the resident's cares.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Unable to speak with resident
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility worked with family to ensure the resident had the care she needed to keep her safe. The facility offered an opportunity to stay at the facility but on a different unit.

Action taken by the Minnesota Department of Health:
No further action 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
	30629	A. BUILDING: _____ B. WING _____	C 12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD I	1 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(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 Initial comments On December 5, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL306295078C/#HL306293085M. No correction orders are issued.	0 000		