Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306833384M **Date Concluded:** July 31, 2023
Compliance #: HL306835539C

Name, Address, and County of Licensee Investigated:
Brookdale of Eagan
1365 Crestridge Lane
Eagan MN 55123
Dakota County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Substantiated, facility responsibility

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 neglected a resident when the resident fell three times in one month and sustained significant bruising and facial fractures. Facility staff failed to document, assess, monitor the resident for injuries, and failed to develop post-fall interventions to prevent further falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Nursing staff failed to follow facility policies and procedures related to falls. Although nursing staff assessed and identified the resident had a history and risk for falls, they failed to document, assess, treat, and monitor after multiple falls occurred. In addition, interventions were not developed or implemented to prevent future falls, the resident's physician was not notified of the fall(s) and/or injury(s), and the resident was not evaluated or assessed until another fall with injury occurred four days later. The resident was sent to the hospital and found to have significant bruising and multiple facial fractures. Upon return from the hospital, the facility failed to complete an assessment, failed to document and monitor the resident's injuries, and failed to implement additional fall interventions to prevent further occurrence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospice services. The investigation included review of the resident's medical records, hospital records, hospice records, and death certificate. At the time of the onsite visit, the investigator observed medication and treatment administration and resident cares provided at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease, atrial ventricular block (when the electrical signal that controls your heartbeat is partially or completely blocked) and major depressive disorder. The resident's service plan identified the resident as cognitively impaired and directed staff to anticipate needs, provide cues, reminders, and redirection as needed. The service plan indicated the resident was independent with the use of a walker and required assistance of one staff member for dressing, bathing, grooming, and incontinent care. The service plan also identified the resident as at risk for falls due to a history of falls, agitation, and behaviors.

Review of facility documentation and the resident's medical record identified the resident fell three times over a one-week period.

The first fall occurred in the dining room of the facility. The fall report indicated the resident was using her walker at the time of the fall and was found sitting near a chair. The incident report did not identify if the resident sustained injury(s) and no additional fall interventions were implemented.

The resident fell in the dining room again the next day. The fall report indicated the resident was using her walker at the time of the fall and was found sitting near a chair. The incident report did not identify if the resident sustained injury(s) and no additional fall interventions were implemented.

Four days later, progress notes identified the resident "had an unwitnessed fall with possible head laceration" and was sent to the emergency room (ER) for evaluation. No fall report was completed.

According to hospital records, the resident presented to the ER with a laceration (deep cut) to the back of the left side of the head, bruising on the left hand and wrist, "racoon eyes [bruising around both eyes]" and notable bruising to the face. Documentation identified the bruising was worse on the left side and appeared to be in various stages of healing. Hospital records indicated ER staff were informed the resident fell three times over the last four days, and the bruising around the resident's eyes was a result of a previous fall. A computed tomography (CT) scan of the head was completed and found no evidence of head injury, but identified three fractures around the resident's left eye, one fracture on the left nasal bone, and a fracture of the maxillary (sinus) bone. The physician referred the resident for evaluation by a facial surgeon due to the fractures. The resident received treatment and discharged back to the facility.

Upon return to the facility, no additional assessment was completed, no changes were made to the service plan, and no additional fall interventions were implemented. The resident's record contained no evidence of the facial fractures identified at the hospital, no evidence of monitoring to the areas of facial bruising, and no documentation on if, or when, the bruising resolved. In addition, there was no evidence the resident's pain was assessed at the time of the fall, following the fall, or after re-admission to the facility.

Three weeks later, the resident admitted to hospice services for Alzheimer's Disease, behavior management, and fall prevention. Approximately one month after the initiation of hospice services, the resident fell a fourth time and fractured her right hip. The resident was placed on bedrest and the resident's need for services was increased to include assistance of two staff and a mechanical lift for transfers. Following the fall, the resident's family met with facility administration and hospice staff to discuss concerns and the facility's management of the resident's behaviors, pain levels, use of PRN medications, and establish better communication on updates of the resident's condition.

During investigative interviews, staff confirmed the resident's facial bruising was a result of the resident hitting her face when she fell in the dining room the second time. However, details of the fall, the assessment of injury, how the injury occurred, pain assessments, continued monitoring of the resident's condition, and/or any treatment provided to the resident, was not included in the resident's record. In addition, there was no evidence of notification to the resident's physician or family of the fall with injury.

During an interview, nursing staff also acknowledged the resident's facial injuries were a result of the second fall in the dining room. Nursing staff indicated the resident's family was notified of the fall and injury but declined for the resident to be assessed at the hospital. However, nursing staff could not recall who contacted the resident's family and there was no documentation available to provide evidence of this discussion with family. Nursing staff was unable to confirm if an assessment was completed following a change in resident's condition and indicated they were not familiar with the facility's fall policy.

Administrative nursing staff interviewed did not recall the resident's second fall, if the resident injured her face, or if an assessment was completed related to a change in the resident's condition.

When interviewed, the resident's family indicated they were not notified of the first fall but were notified of the second fall. Facility staff informed the family that the second fall resulted in the resident hitting her face on the edge of a cupboard or counter. After this notification, the resident's family went to the facility to visit the resident. The family observed the resident was in pain, with black and swollen eyes. The family recalled they requested for staff to bring them ice to hold against the resident's swollen face. The family questioned facility staff at that time if the resident should be sent to the hospital but were told it was not required. When the resident fell the third time, the family was told the resident was sent to the hospital due to a laceration on the back of her head. When family arrived at the hospital, ER staff informed them an x-ray of the resident's face needed to be completed right away and revealed multiple facial fractures.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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

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
Dakota County Attorney General
Eagan City Attorney
City of Eagan Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

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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: HL306835539C/HL306833384M On May 23, 2023, the Minnesota Department of Health conducted a complaint investigation at the above providor, and the following correction orders are issued. At the time of the complaint investigation, there were 30 residents receiving services under the providor's Assisted Living with Dementia Care license. The following correction orders are issued for HL306835539C/HL306833384M, tag identification: 0660 and 1620	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure history, symptoms, tuberculosis (TB) risk assessment screening were completed and documented for one of one, registered nurse, (RN)-B, employees reviewed. In addition, RN-B's employee record did not include her QuantiFERON TB test result. 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 an isolated scope (when one or a	0 660		

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0 660	Continued From page 2 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-B who was the health and wellness director, was hired on June 13, 2022, and started providing direct resident cares after July 8, 2023. RN-B's personnel file contained a QuantiFERON blood test consent form that was signed by RN-B and dated June 13, 2022. RN-B's employee record lacked evidence she completed a TB history and annual TB symptom screening. In addition, her record lacked evidence of the results of her QuantiFERON TB blood test. An email provided by the licensed assisted living director; (LALD)-A dated May 26, 2023, at 7:52 p.m. included RN-B did not complete a TB test upon hire, but a blood test was completed on May 25, 2023, and the licensee was awaiting results. A TB policy was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
01620 SS=G	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	01620		

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01620	Continued From page 3 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 licensee's registered nurse (RN)-B and (RN)-R, reassessed a resident after incidents occurred for one of five residents (R1) reviewed. R1 had three falls with in one month. The resident's assessment at the time of the incidents did not include or accurately reflect the resident's current condition. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 4 Findings include: R1's medical record was reviewed. R1 was admitted to the licensee on January 14, 2021. R1's diagnosis included Alzheimer's Disease, atrial ventricular block, and major depressive disorder. R1's service plan dated May 25, 2022, indicated the resident had a history of falls with injury, assist with medication administration of all medications, and ambulated independently with frequent reminders to use walker when ambulating. Fall 1: The resident's medical records dated July 7, 2022, at 2:00 p.m., indicated the resident had a witnessed fall in the licensee's dining area. The record indicated the resident denied pain but lacked documentation that a nurse assessed the resident or family was notified of the fall. The resident's medical record also indicated the resident had a change in the ability to transfer, a gait disturbance, and had her walker in use at the time of the fall. A new post-fall intervention to remind the resident to use her walker when ambulating was included and dated July 8, 2022. The resident's post fall medical record was signed by the registered nurse (RN)-B and indicated the service plan was updated as of July 13, 2022. No further information was provided regarding this fall. The resident's progress notes dated July 7, 2022, at 1:57 p.m., indicated the resident received a scheduled dose of Acetaminophen and Tramadol for pain and noted the resident had a fall. Fall 2:	01620		

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01620	Continued From page 5 The resident's medical record dated July 8, 2022, at 4:00 p.m., indicated the resident had a witnessed fall in the licensee's dining area. The record indicated the resident denied pain but lacked documentation that a nurse assesed the resident or family was notified of the fall. The resident's medical record also indicated the resident had a change in the ability to transfer, a gait disturbance, and had her walker in use at the time of the fall. A post-fall intervention dated July 8, 2022, included for the resident to use her walker. The resident's post fall medical record was signed by RN-B and indicated the service plan was updated as of July 13, 2022. No further information was provided regarding this fall. Fall 3: The resident's medical record dated July 12, 2022, at 3:30 p.m., indicated the resident was found on her back in the resident's living area and was not using her walker at the time of the fall. The record indicated this fall occurred near a chair in a poorly lit room. The resident's medical record also indicated the resident had sustained a laceration on the back of her head and stated she was in pain. The record also indicated the resident had a change in the ability to transfer, and a gait disturbance. A post-fall intervention included for the resident to use her walker. The resident's post fall medical record was signed by RN-B and indicated the service plan was updated as of September 1, 2022. The resident's progress notes dated July 12, 2022, at 4:10 p.m., indicated the resident had an unwitnessed fall with possible head laceration, was alert upon transfer to the hospital. The resident's hospital records dated July 12,	01620		

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01620	Continued From page 6 2022, at 4:45 p.m., indicated the resident had a fall to her left back scalp and bruises around her left eye. The records indicated the resident's daughter informed the hospital physician that the bruising around the resident's left eye had been from a fall four days prior to the hospital visit. The resident's hospital records, same date and time, indicated an x-ray was completed which revealed two fractures to the resident left orbital bone, a fracture to the left nasal bone, and a fracture to the maxillary bone. Hospital records dated July 12, 2023, at 8:47 p.m., indicated the resident would be discharged back to the facility with the current orders and an order to consult a facial surgeon. The resident's progress notes dated July 12, 2022, at 10:12 p.m., indicated the resident was administered the following medication as ordered for a pain level of 4 out of 10: Tramadol 0.5 milligrams (mg) by mouth (po) every twelve hours as needed, (PRN), for pain in her eye. The progress notes indicated the pain medication had been effective in relieving the resident's pain. The resident's nursing assessment dated July 20, 2022 and signed by RN-B indicated the resident required two person assist with all transfers. The resident's hospice medical records dated July 29, 2022, indicated the resident started hospice services due to diagnosis of Alzheimer's Disease, increase in staff assistance needs, and history of falls. An email sent to the Minnesota Department of Health (MDH) investigator, dated June 13, 2023, at 9:17 a.m., from RN-B, indicated the resident's Individual Abuse Prevention Plan was been updated to include the three falls, as she had not	01620		

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01620	Continued From page 7 been trained on that process yet. The email indicated there was not a fall intervention update after the fall that occurred July 12, 2022. An email sent to the MDH investigator dated June 16, 2023, at 1:25 p.m., from the licensed assisted living director (LALD)-A, indicated that there was no documentation completed for the fall on July 8, 2022. During an interview on June 12, 2023 at 10:05 a.m., RN-B recalled the resident fell on July 7, 2022, and broke her eyeglass frames. RN-B also believed there was a skin assessment completed because of a possible bruise. RN-B did not remember a fall that occurred on July 8, 2023. During an interview on June 12, 2023, at 2:35 p.m., the resident's family member (FM)-L, stated the resident fell on July 7, 2022, but was not notified of the fall until the resident fell again on July 8, 2023, and was informed the resident hit the left side of her face against a counter. FM-L did not recall the resident's glasses being broken after any of the falls. FM-L went to the facility after the fall on July 8, 2022, and at first could not remember asking staff if the resident should go to the hospital, but later in the interview, recalled inquiring with staff if the resident should be sent to the hospital, at which the staff told FM-L that the resident did not need to go to the hospital. FM-L could not remember which staff notified her of the fall or which staff told her the resident did not need to go to the hospital. FM-L requested ice so she could place it on the resident's face as it was very swollen, bruised, and the resident stated the areas hurt. FM-L was notified of the fall that occurred on July 12, 2023, which resulted in a laceration to the back of the head. FM-L was notified by staff and met the resident at the	01620		

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01620	Continued From page 8 hospital. FM-L stated the resident did not need stitches but the hospital physician was concerned about the bruising on the resident's face and ordered an x-ray. FM-L recalled the resident having several fractures found around her eye. During a subsequent interview on June 14, 2023, at 9:03 a.m., FM-L stated a clarification and included that the fall on July 8, 2022, resulted in the resident having a swollen eye area and bruise to the nose area. FM-L also stated she had no information as to why the resident was not sent to the hospital; staff just told her the resident did not need to go. During an interview on June 14, 2023, at 11:02 a.m., a licensed practical nurse (LPN)-E, stated when placing the facility's paper post fall documents into the electronic charts, she remembered the fall on July 7, 2022, resulted in no injuries but could not remember if a nursing assessment had been completed. LPN-E recalled the July 8, 2022, fall and the resident hitting her face, causing an eye and nose injury. She did not remember if a nursing assessment was completed or why the resident was not sent to the hospital, but added that she recalled the family member did not want the resident to go to the hospital. LPN-E stated she and another staff member found the resident on her back in the resident's room on July 12, 2022. LPN-E recalled the resident had a laceration to the back of her head and was sent to the hospital. LPN-E notified the resident's family member of the fall and injury. LPN-E stated she recalled the resident having facial fractures and already having had orders for pain medications. LPN-E stated she could not recall the date, but after the fall on July 12, 2023, LPN-E recalled having communication with the resident's family about placing the resident on	01620		

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01620	Continued From page 9 hospice services. The licensee's provided Fall Policy dated April 2023 included: 5. vi: The resident service plans and interventions will be updated after a fall. The licensee provided Fall Intervention and Clinical Guideline policy dated August, 2021, included on page 4C: 1. Evaluation of the resident and injuries that require immediate treatment. 3. Second evaluation completed by the health and wellness director or nurse. 5. Interventions are documented. Implemented and placed on the resident's service plan. The licensee provided Head Injury Policy included: For minor head injury, contact the nurse to direct the next steps to the unlicensed staff, the nurse contacts the provider within one to two hours of the head injury and the provider recommends hospital transport. If transport to hospital is recommended call 911 and contact the resident legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		