Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306846644M
Compliance #: HL306842405C

Date Concluded: February 27, 2024

Name, Address, and County of Licensee Investigated:
Brookdale West St. Paul Memory Care
315 Thompson Ave. E
West St. Paul, MN 55118
Dakota County

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

Evaluator's Name: Brooke Anderson, 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 the resident when the resident left a secured unit, walked away on foot approximately 1.5 miles from the facility, and fell, striking the left side of his face/head, left arm, and hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to identify the resident's risk of elopement and failed to develop and implement interventions to protect the resident's health and safety. In addition, the facility had no systems in place to ensure facility exits were secure and in proper functioning order, and the resident eloped from the facility.

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

records, and a paramedic report. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, left-eye blindness, and diabetes. The resident's service plan included assistance with dressing, diabetic management, and medication management. The resident's assessment indicated the resident had impaired judgement due to cognitive decline, was not at risk for elopement, and had no history of elopement or wandering. The resident's service plan included safety checks every four to six hours during the night.

The resident's record included a progress note which indicated the resident attempted to exit the facility via the main entrance doors. A staff member (staff member #1) redirected the resident, and the resident stated he would break the windows to get out of the facility. Later, he was found banging on the windows in his room with his cane.

Ten days later, an incident report indicated facility management was contacted at 6:09 a.m. by staff who reported the resident missing. Staff member #2 realized that the resident was missing at 5:50 a.m. when bed checks were completed, and staff member #3 reported the resident was last seen at 1:00 a.m. Facility management notified the police department and reported the resident missing.

A paramedic report indicated a passerby found the resident at 5:36 a.m. The resident was awake and talking but very confused. The resident was unable to recall his address, date of birth, how he fell, when he fell, or how long he had been on the ground. The resident was found with a medical bracelet that identified cognitive impairment and the resident was transported to the emergency department.

Hospital records indicated the resident was diagnosed with an orbital contusion (bruising around the eye) and abrasions (scrapes of the thin layer of skin). The hospital discharged the resident back to the facility with instructions to ensure the resident was not able to leave the facility unsupervised.

A facility investigation indicated the back left door of the facility (that opened to an enclosed patio) was opened at 12:53 a.m. The patio gate was opened at 12:56 a.m. and shut at 12:57 a.m. A staff pager was alerted at the time the gate was opened, and there was evidence of the pager being silenced, but staff denied silencing the alarm. The resident was gone for approximately four and a half hours and was found a mile and a half away from the facility.

The resident's service delivery record included no documentation of safety checks or any other services for the week of the incident. It was unable to be determined when the resident was last seen or when care was last provided to the resident. Staff reported that the resident was last seen at 1:00 a.m.; however, a review of the facility internal investigation indicated the resident left out of the patio gate at 12:57 a.m.

During an interview, staff member #1 identified the resident as an elopement risk and stated the resident had a pattern of exit-seeking behavior and required staff redirection. Staff member #1 was not sure if the facility nurse knew about this behavior or if it was documented anywhere. Staff member #1 also stated the resident required every two-hour safety checks and often talked about leaving the facility.

During an interview, staff member #2 stated the resident was on every two-to-four-hour safety checks but was unable to provide a time for when the resident was last checked on the night of the elopement. Staff member #2 stated staff pagers beeped when a door was opened or closed, but stated he was not wearing the pager the night of the incident. The resident got out the back left door of the building, which was not locked, to the enclosed patio and left out the patio gate. Staff member #2 stated he didn't know much about the gate's keypad, and the maintenance director was the only person with the code. Staff member #2 stated he discovered the resident was missing during his morning rounds. He reported this immediately to staff member #3, and they conducted a search for the resident and contacted police and facility management.

During an interview, staff member #3 stated the resident was on every four-to-six-hour safety checks. Staff member #3 stated she did not wear the pager the night of the incident, and it was left on the medication cart. Staff member #3 stated the pager alarmed one time when staff member #2 went out the front door, but that was the only time she heard the pager alert. Staff member #3 assumed the back doors to the patio were still locked because no one told her they were unlocked for the spring. Staff member #3 stated that when they completed their final resident checks, they discovered the resident was missing and notified facility management.

During an interview, a maintenance staff member stated she was not sure if the back door to the enclosed patio was unlocked the night of the incident, but leaving one back door unlocked was the facility practice in the summer months. The maintenance staff stated that after the incident, she identified that the gate keypad had several codes that opened the gate, so it was not unrealistic to think that the resident typed in multiple numbers and the gate opened. After the incident, the keypad codes were erased, and the gate was secured with one code. A lockable cover was placed over the keypad and locked with a key.

During an interview, facility management stated that all doors and patio gates were secured with a keypad and code. An alarm would sound if anyone attempted to exit the door without using the code and staff carried pagers to alert them anytime a door was opened, even if a code was used. Facility management stated the only reasonable explanation for the elopement was that the resident figured out the codes. Facility management stated staff education was completed after the incident and the keypad codes were changed.

During an interview, a hospital staff member stated that the facility would not disclose how the resident was able to get out of the secured memory care unit on the night of the incident. The hospital staff member stated the facility refused to communicate with the hospital and family about how the facility was going to keep the resident safe in the future.

During an interview, a family member stated she was not aware of the resident attempting to leave the facility prior to the incident. The family member stated there was no way the resident could have remembered the door code; he could not even remember his phone number. The family member stated that on the night of the incident the resident was found in a ditch near the road by a passerby. The resident had broken glasses, cuts on his face, and bruises all over. The family was provided conflicting reports from the facility on how the resident was able to leave unsupervised. The family member stated the resident was upset and shaken after the incident and no longer resided at the facility.

Facility documents lacked evidence the resident was assessed following his return from the hospital, and no new interventions were implemented to prevent future elopements.

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, resident no longer resides at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation, completed staff education, changed the codes on the gate, and locked the back door.

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
Dakota County Attorney
West St. Paul City Attorney
West St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30684	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL MC	315 THOMPSON AVENUE EAST 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 ******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: #HL306842405C/#HL306846644M On January 22, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders were issued. At the time of the complaint investigation, there were 17 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued for #HL306842405C/#HL306846644M , tag identification 2320 and 2360.	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.	
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services	02320		

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02320	Continued From page 1 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: The licensee failed to provide appropriate care, services, supervision, and monitoring for one of one residents (R1) who resided in a secure memory care unit with severe cognitive impairment who was able to elope from the secured memory care unit and was found outside. This had the potential to affect all 20 residents who resided in the secured memory care unit. 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). Findings include: R1 was admitted to the facility on April 24, 2023, with diagnoses including Alzheimer's disease, blindness in the left eye and diabetes mellitus. R1's service plan dated May 1, 2023, included assistance with all activities of daily living (ADL)s including dressing, bathing, toileting, blood sugar checks, catheter care and medication	02320		

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02320	Continued From page 2 management. R1's undated service plan, included bed checks every 2 hours and as needed. R1's services delivered record dated May 2023, indicated safety checks every two to four hours, there was no documentation safety checks were completed. R1's assessment prior to the incident dated May 1, 2023, indicated R1 was not a risk of elopement, had no history of elopement or wandering, and had impaired judgement due to cognitive decline. The assessment indicated R1 staff assistance with toileting/incontinence care every two to four hours during the day and as needed at night. R1's progress notes dated April 25, 2023, indicated R1 was trying to get out the main entrance. Staff attempted to redirect. R1 stated he would break the windows and was swinging his cane. R1's progress notes date April 25, 2023, at 9:29 a.m., indicated when unlicensed personnel (ULP)-G entered R1's room he was banging on the windows with his cane. ULP-G administered R1 an as needed anti anxiety medication for agitation. During an interview on January 30, 2024 at 11:19 a.m., ULP-G stated R1 was to be checked on every two hours. ULP-G stated R1 was depressed and would often talk about getting out of the facility. R1 would exit seek and was a high elopement risk. The licensee failed to update R1's assessment	02320		

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02320	Continued From page 3 and individual abuse prevention plan (IAPP). A facility incident report, dated May 5, 2023, indicated ULP-C called Executive Director (ED)-A at 6:09 a.m. and reported R1 was missing. ED-A advised to check every room and call back in five minutes. ULP-C called back and reported the last time R1 was seen was 1:00 a.m. ULP-C reported realizing R1 was missing at 5:50 a.m. when ULP-B was completing bed checks. At 6:20 a.m. ED-A called 911 to report R1 missing. A paramedic report dated May 5, 2023, indicated a passerby driving by found R1 at 5:36 a.m. The resident was awake and talking but very confused, unable to get up, and was transported to the emergency department. R1's hospital records dated May 5, 2023, indicated R1 was diagnosed with an orbital contusion and abrasions. R1 was discharged back to the facility. A facility investigation dated May 9, 2023, indicated on May 5, 2023, the door code on the keypad for the patio gate was punched at 12:56 a.m. The pagers alerted the back door was opened but ULP-B and ULP-C did not respond to the notification. Another notification was sent to the pagers 12 seconds after the gate was opened indicating the gate was closed at 12:57 a.m. The notification was continuous until it was acknowledged by ULP-B and ULP-C. ULP-B and ULP-C did not physically go check the back gate but did acknowledge the notifications that the gate was open and closed. The facility investigation indicated, "Actions to consider" install cameras at front and rear of the memory care building and keep rear exit doors of the building locked at all times, even during daytime	02320		

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02320	Continued From page 4 hours. After the elopement the licensee failed to update R1's assessment and IAPP. During an interview on January 22, 2024, at 5:05 p.m. ULP-B stated R1 was to be checked every two to four hours. ULP-B didn't know when R1 left the building but found he was gone when he completed his check. ULP-B stated the pagers alert when the doors open and close, but ULP-B did not have a pager on that night. ULP-B stated R1 got out the back left door which was not locked and could be opened by pushing it without an alarm sounding. ULP-B stated he didn't know much about the gate, but ULP-B assumed the gate was locked. The only person that knew the code was the maintenance director. ULP-B stated he assumed R1 entered a bunch of numbers and that was how R1 got out. During an interview on January 23, 2024, at 7:21 a.m. ULP-C stated R1 was to be checked every four to six hours. ULP-C stated ULP-C and ULP-B completed their initial checks and when they completed their final checks that was when they identified R1 was gone. ULP-C stated the pager was on the medication cart during her shift. ULP-C stated the pager alerted her when ULP-B went out the front door but that was the only alert her heard. ULP-C stated she assumed all the doors were locked because no one told her the doors were unlocked for spring. ULP-C stated management was notified when they found R1 was missing. During an interview on January 23, 2024, at 10:32a.m. maintenance director (MD)-D stated the schedule of nightly checks was dependent on the resident but were mostly every two to four	02320		

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02320	Continued From page 5 hours. MD-D stated she didn't think the back door was unlocked but unlocking it was normal practice in the summer months. MD-D stated when she got to work the morning of the incident, she attempted to change the code on the gate and identified that any of the old or new code could have opened the gate. During an interview on January 25, 2024, at 11:00 a.m. hospital social worker (HSW)-F stated R1 was found 1.5 miles away from the facility. HSW-F stated the licensee would not give family or the care team information regarding how R1 eloped from the facility. HSW-F stated the licensee would not answer calls or return calls to ensure a plan was in place when R1 returned to the facility to keep R1 safe from eloping again. During an interview on January 22, 2024, at 11:30 a.m. executive director (ED)-A stated the licensee completed quarterly elopement drills and training. Staff are trained upon hire about elopement as well as vulnerable adults. ED-A stated staff are trained on the individual needs and vulnerabilities of the residents. ED-A stated each time a door opened or closed an alert was sent to the pagers. When staff received a page, they were supposed to go and check on the door. ED-A stated the licensee's investigation concluded R1 knew the code and typed it in to the keypad to exit the facility. ED-A denied R1 had a history of elopement. During interviews and documentation review, the facility failed to establish a consistent time R1 was assessed to receive safety checks. The facility policy and procedure titled "Missing Resident Plan Policy" dated August 2021 indicated the definition for elopement was any	02320		

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02320	Continued From page 6 incident where a resident leaves the secured memory care area of the community or the secured courtyard, unescorted, with or without injury. The facility management must review the missing resident plan at least quarterly and document any changes to the plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
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(s) 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. No plan of correction is required for this tag.	02360		