Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306913042M
Compliance #: HL306913061C

Date Concluded: September 13, 2024

Name, Address, and County of Licensee Investigated:
Brookdale Eden Prairie
7513 Mitchell Rd
Eden Prairie, MN 55344
Hennepin County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Not Substantiated

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 facility failed to provide supervision, the resident exited the building, fell, and fractured her wrist.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did exit through a secured exit and fell, staff responded immediately and according to facility protocol.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's assessments, service plan, internal investigation and elopement policy. Also, the investigator completed an onsite visit to observe staff to resident interactions in the secured memory care as well as how the exit door functions in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and chronic pain syndrome. The resident's service plan included verbal cues for dressing, and toileting assistance. The resident's assessment indicated the resident walked independently without any devices. The resident wandered throughout the community and required redirection and often set off door alarms attempting to leave the facility. The resident was verbal but did not always communicate her needs.

One day the resident exited the facility without supervision. Meanwhile, the facility alarm-system alerted caregivers an exterior exit door had been opened who immediately responded. The resident was found a short distance from the door on the ground having sustained a wrist fracture from an apparent fall. Three caregivers responded to the alarm.

Facility documents indicated the staff members stayed with the resident, obtained, vital signs, called the on-call nurse, and contacted the resident's family. Initially, the staff members were directed to assist resident off the ground and back into the facility where ice was applied to her wrist. Later, the resident was diagnosed with a wrist fracture from the fall.

Facility characteristics and fire exits

The facility was licensed for assisted living with dementia care and was a secured memory-care building. To enter or exit, the building, a visitor required a facility staff member to allow passage through either the main or the back service-door. The facility included two "neighborhoods" (units) which each included three secured fire exits (six total), which were alarmed at the end of each wing.

Each secured fire exit included a two-door system which meant to exit a person passed through one door into a small entry area to reach the second door. If or when a person opened the first door an alarm was triggered and continued to sound until and unless the alarm was deactivated using a key carried only by employees. The second door had a bar that required being pushed for 15 consecutive seconds to open which also caused a second alarm to sound. Inside the facility at multiple locations the alarm system included a panel which displayed which door had been breached so that staff could readily know which door to go check if an alarm went off.

Training records indicated the facility trained it staff members on how to monitor the alarm system and how to respond quickly to any alarms indicating someone had left the building.

The investigation included an unannounced onsite visit which included a test of the facility response to the fire exit alarm system during which multiple staff members responded within a short period of time to the correct door.

Interviews

During an interview, a nurse stated the resident was constantly walking and wandering about the facility. The nurse stated staff members were able to visually observe the resident due to

her constant wandering in the main common areas. The resident's attempts to leave the facility were increased during periods of anxiety and after phone calls with family. The nurse stated initially the resident did not seem injured based on the update over the phone, however when the nurse assessed the resident in-person the next morning she requested an x-ray and further evaluation.

During an interview, a family member stated they chose the facility as it was secured and for the location. The family member stated approximately six months before the incident the resident had discovered if she pressed on the bar long enough the alarm signals, but the door eventually would open. The family member stated the nurse requested medication to help with the resident's anxiety as the resident had elopement attempts but not always out the same door.

During an interview, a manager stated resident elopement attempts had increased three months prior to the incident. The manager stated the resident was able to explain how to exit the building so the facility staff members were on high alert when they heard the alarm go off.

During an interview, a staff member from maintenance stated the facility conducted monthly elopement drills. The staff member stated the doors are checked weekly to ensure they are functioning properly.

During an interview, multiple unlicensed caregivers, who had been working the day the resident exited, stated she was doing her normal roaming of going up and down the hallways. Three caregivers heard the alarm and responded to the alarm with the resident being found already on the ground outside the exit.

In conclusion, the Minnesota Department of Health determined neglect 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.

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

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

Action taken by facility:
No action required.

Action taken by the Minnesota Department of Health:
No further action taken 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
	30691	A. BUILDING: _____ B. WING _____	C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDEN PRAIRIE	7513 MITCHELL ROAD EDEN PRAIRIE, MN 55344

(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 On August 19, 2024,, the Minnesota Department of Health initiated an investigation of complaint #HL306913061C/#HL306913042M. No correction orders are issued.	0 000		