Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306919626M
Compliance #: HL306917566C

Date Concluded: May 13, 2024

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

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

Evaluator's Name:
Katie Germann, 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 to provide the appropriate level of supervision to resident #1 (R1) and resident #2 (R2). The residents had a physical altercation, R2 pushed R1, and R1 fell and fractured her left femur (hip bone). R1 died two months later from her injury's.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. R1 and R2 had a history of resident-to-resident physical altercations and wandering into other residents' rooms. The facility failed to ensure R1 and R2 had interventions in place to ensure the residents safety. R1 wandered into R2's room, where a physical altercation took place. R1 and R2 both experienced falls from being pushed during the altercation. R1 experienced pain, was sent to the hospital the next morning, and diagnosed with a broken hip.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and resident's families. The investigation included review of medical records, nursing assessments, police reports, ambulance run report, recorded camera footage of the incident, facility policies and procedures, and staff training records.

R1 resided in an assisted living memory care unit. The resident's service plan included assistance with medications, meals, and bathing. The resident's assessment indicated the resident had a history of going into other residents' rooms and taking their belongings as well as verbal and physical aggression with staff and other residents.

R1's assessments had no specific interventions to direct staff on how to supervise the resident to prevent R1 from wandering into others room putting the resident and other residents' safety at risk.

R2 resided in an assisted living memory care unit. The resident's service plan included assistance with medications, dressing, grooming, bathing, and toileting. The resident's assessment indicated the resident has a history of yelling at staff and other residents.

Review of recorded video footage [no audio] from R2's room the overnight shift of the incident, R2 is observed sleeping in her bed in a dark room. R1 opened R2's door, turned on the overhead lights, and closed the door. R2 got out of bed and grabbed R1's right arm. R1 swatted R2 away and continued to walk into the room. R2 pushed R1 back towards the door and pushed R1 into a wall. R1 pushed R2 onto the bed and the residents continued to swing at each other and R2 began to kick R1. R2 stood up from the bed, and R1 pushed R2 back onto the bed and hit R2 in the face with a closed fist. R2 attempted to get off the bed and fell to the floor. R2 got up off the floor, stood by R1 for a few seconds and ran out of the room. R1 took some of R2's clothing and left the room. Three minutes later, R2 was observed coming back into her room with the piece of clothing R1 took. R2 sat on the edge of her bed rocking back and forth and was holding her right hand up looking at it. Approximately one minute later, two unlicensed staff come into R2's room and look at R2's hand. One unlicensed staff took out his phone and appeared to walk out of the room. The other stayed with R2 for a minute and appeared to be talking with her.

The facility had no cameras in the hallway.

A facility investigation of the incident, completed two months after the incident, indicated after an altercation between R1 and R2, R1 had a fall in the hallway. The unlicensed staff interviewed stated R1 was found sitting on the floor in the hallway saying she could not get up. R2 was standing in the hallway as well and her finger was bleeding. R2 was observed with a bleeding, broken fingernail, and R1 could not stand or walk. The staff contacted the nurse administrator. Initially, the unlicensed staff reported R1 was not having pain. Later when staff checked on R1, the resident stated she had pain in her hip. The nurse administrator was contacted again to report R1's pain and the nurse stated she would be in early in the morning to check on the

resident. During the morning shift another nurse checked on R1 and indicated the resident could not get out of bed and ate breakfast in her room, which she had never done before. The morning nurse reported the pain and change of behavior to the facility nurse who told the morning shift nurse to monitor R1. Later that morning, the camera in R1's room alerted staff R1 was on the floor. The facility nurse made the decision to send R1 to the hospital, where she was found to have a fracture in her left femur.

An ambulance report indicated Emergency Medical Services (EMS) were called to assist with R1 due to left hip pain. The report indicated facility staff reported R1 had an altercation with another resident and a fall approximately 10 hours prior. Facility staff reported to EMS the resident had a gradual decline in mobility since the fall. EMS found R1 kneeling next to her bed upon arrival. The report indicated when EMS assisted R1 to the stretcher, she yelled out in pain. EMS transported R1 to the hospital.

Hospital notes indicated R1 arrived at the hospital complaining of left hip pain. The notes indicated EMS had reported R1 had an altercation which another resident, during which R1 was pushed and fell. Hospital notes indicated R1 had a closed fracture of the left femur and traumatic rhabdomyolysis (muscle fibers die and release their contents into the blood stream). The notes indicated R1 underwent an open reduction and internal fixation surgery (ORIF). The resident was discharged to another facility with end-of-life hospice care services.

R1's death certificate indicated R1 died approximately two months later from a ground level fall during physical altercation; and staphylococcus aureus pneumonia (a type of bacteria) complicating recovery of left hip fracture.

When interviewed unlicensed personnel (ULP-1) stated the night of the incident he was alerted by the facility camera system there was a fall in R2's room. ULP-1 stated when he arrived in the hallway outside of R2's room, R2 was on the floor bleeding from her finger and had a broken fingernail. Later on, he found R1 leaning against a wall saying she could not stand up. ULP-1 asked another unlicensed personnel (ULP-2) to assist him with R1. ULP-1 stated it was common for R1 to be up overnight wandering and going into other residents' rooms. He stated R1 was difficult to redirect because she became verbally and physically aggressive. ULP-1 stated sometimes staff would have to lock all of the residents' doors to prevent R1 from wandering into other rooms. ULP-1 stated he contacted the facility nurse and informed her R1 was in pain in her leg. The facility nurse told ULP-1 she would come into the facility early in the morning to assess R1.

During an interview, ULP-2 stated the night of the incident he was called by ULP-1 to assist with a fall. ULP-2 stated when he arrived in the hallway, he saw R2 standing in the hallway crying and bleeding from her hand and R1 was a few feet away leaning against the wall, unable to stand on her own. ULP-2 stated he got a wheelchair for R1 and assisted the resident to bed. ULP-2 stated R1 was complaining of pain in her leg.

During interview a facility nurse stated R1 and R2 had “issues” with each other from the day R1 moved in. She stated R2 had a history of being oppositional and R1 had a history of aggressive behavior toward other residents. The nurse stated the intervention to prevent R1 from acting aggressive toward other residents included medication, engagement, and meeting with a dementia care specialist to find other ways to engage R1. The nurse stated she did not remember what the dementia care specialist recommended, and she did not document what the recommended interventions were, but the interventions were communicated to staff verbally.

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

Action taken by facility:
No action taken.

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
Hennepin County Attorney
Eden Prairie City Attorney
Eden Prairie Police Department

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 03/27/2024

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 ******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: #HL306917566C/#HL306919626M On March 27, 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 26 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306917566C/#HL306919626M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) reviewed (R1 and R2) were 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		