Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315738806M
Compliance #: HL315736383C

Date Concluded: April 11, 2024

Name, Address, and County of Licensee Investigated:
Willows of Ramsey Hill
80 North Mackubin Street
Saint Paul, Minnesota 55102
Ramsey County

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

Evaluator's Name: Nicole Myslicki, 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 resident 1 and resident 2 when resident 1 wandered into resident 2's room. Resident 2 sustained a fracture in her right wrist and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was a lack of evidence proving resident 1 physically hurt resident 2. Resident 1 did not have a history of being aggressive toward other residents and did not normally wander into resident rooms. The incident occurred shortly after morning rounds while staff prepared breakfast, started to pass medications, and helped residents get up for the day. Facility staff responded to the incident less than 15 minutes from when resident 1 entered resident 2's room and sent resident 2 to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records,

resident 2's hospital records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed wandering residents and how staff monitored them.

Resident 1 and resident 2 resided in an assisted living memory care unit.

Resident 1's diagnoses included dementia and left eye blindness. Resident 1's service plan included hourly safety checks, assistance with morning cares at 6:15 a.m., a treatment at 6:15 a.m., and medication administration at 6:35 a.m. Resident 1's assessment indicated resident 1 had limited range of motion in her right arm but walked independently. Resident 1's individual abuse prevention plan (IAPP) indicated resident 1 did not appear to pose a threat to other vulnerable adults.

Resident 2's diagnoses included dementia and osteoporosis. Resident 2's service plan included assistance with medication administration. Resident 2's service plan identified resident 2 as independent with toileting, mobility, and getting ready, and indicated resident 2 did not receive safety checks at night. Resident 2's assessment identified resident 2 was at risk for falls. A risk agreement in resident 2's record indicated she and her family did not want safety checks during the overnight shift.

An incident report indicated resident 2 had been found on the floor of her room, bleeding from the right wrist. Apparent injuries included a skin tear, pain, inability to move her wrist, and a broken bone. The facility called 911 and emergency medical services (EMS) transferred the resident to the emergency department (ED). The report identified resident 1 as a witness to the incident.

An internal investigation indicated a nurse received a call at 7:05 a.m., informing her of resident 2's wrist injury and fall. Unlicensed personnel (ULP) 2 found resident 2 on the floor at 7:00 a.m., and EMS arrived about 7:20 a.m. ULP 1 found resident 1 sitting in a rocking chair in resident 2's room with blood on the bottom of her dress. The investigation included interviews with staff and family who reported resident 1 had never been violent or combative. They also identified resident 1 with being easily redirectable.

Resident 2's hospital record indicated resident 2 had a fracture of her wrist in two places. Resident 2 admitted to the hospital for four days until she discharged to a transitional care unit.

Surveillance footage provided by family showed resident 1 entered resident 2's apartment and closed the door. Resident 1 walked through the kitchenette, using the countertops to guide her. Resident 1 went out of sight, but the camera continued recording. Resident 2 asked who was there and stated not to come in. Resident 2 stated resident 1 was not supposed to be there and asked where she came from. A thud could be heard, then resident 2 started yelling resident 1 broke her wrist and instructed her to get out. Resident 1 never responded or spoke to resident 2. Surveillance footage showed resident 2 then scooted herself across the floor, through the

kitchenette to the door, using one arm and her legs. Resident 2 opened the door and began yelling for help. The footage showed the entire incident, from the time resident 1 entered the room to staff finding resident 2, took less than 15 minutes.

During an interview, a nurse stated she watched surveillance footage provided by resident 2's family. Resident 1 walked into resident 2's room. Resident 2 sounded startled and upset someone came into her room, then a thud could be heard. The nurse thought resident 2 fell and hurt her wrist. The nurse investigated the incident and spoke with the ULPs about what happened. Additionally, the nurse held a conference with resident 2's family.

During an interview, ULP 1 stated resident 1 never showed aggression to other residents and rarely wandered into other resident rooms. When she did, staff easily redirected her out of the room. Staff were supposed to complete safety checks every hour, but resident 1 mostly just walked the halls and the communal room, so they could see her. But if staff did not see her, they would go check on her. When ULP 1 first arrived at 6:00 a.m., she and the other daytime ULPs rounded on the residents with the overnight ULP. Then she started getting the kitchen ready for breakfast. ULP 1 stated resident 2's family did not want staff going into resident 2's room until 7:00 a.m. When the incident occurred, she had been talking with the overnight ULP about the shift, when ULP 2 ran to notify her resident 2 had been found by her door on the floor. They went to resident 2's room, sat her up in a chair, found resident 1 sitting in a rocking chair in resident 2's room, and started calling family, nursing, and 911. Resident 2 told ULP 1 she fell and felt a lot of pain but did not say much more than that. Based on resident 2's injury and where blood was located, ULP 1 thought resident 2 tripped over the edge of her bed and fell on the ground because they did not find any blood on her bed. Resident 1 had blood on the bottom of her dress but did not have any blood on her hands, nor did she have any injury.

During an interview, ULP 2 stated resident 1 did not show aggression to other residents. She could not talk or hear. Resident 1 usually just walked the halls and did not normally go into other resident rooms. At the time of the incident, ULP 2 had been administering medications to a resident near resident 2's room. ULP 2 came out of that resident's room and saw resident 2 on the floor in her doorway. ULP 2 got ULP 1, and they helped resident 2 into a chair. During this time, resident 1 remained seated in resident 2's chair, looking scared. Resident 1 had blood on her dress but not on her hands. After this, the facility increased how frequently they checked on resident 1 to every 15 minutes.

During an interview, resident 2's family member stated resident 2 had been in good health, walked a lot, and just had a bad memory. Resident 2 had not previously fallen at the facility. The facility told her resident 2 must have fallen, even though resident 2 could be heard on the video telling resident 1 she was killing her. The family member stated she did not think resident 2's door always had to be locked. Sometimes resident 2 locked the door when she left her room, but she tended to forget to lock it while in her room. Family placed a sign on the inside of resident 2's door, reminding her to lock it. Resident 2 lost some functionality in her wrist, but her hand did still work. Additionally, resident 2 remained on pain medications for quite a while

due to back pain from the incident. The family member stated resident 2 did not remember the incident or even that her wrist had broken.

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.
Insert maltreatment definition here.

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: Resident 1: No; deceased. Resident 2: No, unable due to cognitive impairment.
Family/Responsible Party interviewed: Resident 1: No; declined to interview. Resident 2: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed an internal investigation, met with resident 2’s family, and re-educated staff on completing safety checks on wandering residents, hourly rounding, and the importance of checking and locking doors. The facility sent resident 2 to the hospital for treatment and increased resident 1’s safety checks to every 15 minutes.

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
	31573	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102

(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 February 29, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL315736383C/#HL315738806M. No correction orders are issued.	0 000		