Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378693462M
Compliance #: HL378693725C

Date Concluded: August 2, 2024

Name, Address, and County of Licensee Investigated:
Broadwell Senior Living
3025 North Harbor Lane
Plymouth, MN 55447
Hennepin County

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

Evaluator's Name: Peggy Boeck
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 a resident when they failed to monitor the resident when eating. The resident choked on food and passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility ensured all staff working in the memory care unit were aware of the resident's tendency to overfill his mouth with food and directed staff to monitor the resident at mealtime. The resident began choking, then collapsed on the staff, who made efforts to get the food out of his airway and called 911 when the resident became unresponsive.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death record, medical examiner records, facility incident reports,

personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff/resident interactions during mealtime.

The resident lived in an assisted living memory care unit for less than a year. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with reminders for meals, getting to, and returning from meals. The resident's assessment indicated the resident received a normal diet, was motivated by snacks, and although often overfilled his mouth with food, had no history of choking.

An incident report indicated a staff realized the resident was choking on a mouthful of food, so she tried, but was unable to remove the food. When the resident became unresponsive, the staff called 911.

During an interview, a staff member stated the resident loved food and would often fill his mouth and then chew it. The staff stated on the day of the incident, she asked the resident to come over to the cart for his medication. As the resident approached her the staff noticed his mouth was full of food. The staff stated she grabbed a garbage can and told the resident to spit it out. The staff stated the resident shook his head "no". The staff said she looked down to pop out a pill, and when she looked up the resident was moving toward her. The staff stated she thought maybe he was choking, although he had no throat grabbing and made no sounds, she patted him on the back. The staff stated the resident then began to fall and she lowered him to the floor. The staff stated he looked blue, and she could tell he was not breathing so she yelled for her co-workers and tried to remove the food from his mouth. The staff stated she began abdominal thrusts, but nothing came out of his mouth. The staff stated she then called 911.

An investigative report indicated law enforcement and emergency responders arrived at the facility and began cardiopulmonary resuscitation (CPR). The report indicated the resident had received chicken and rice for lunch, finished, staff cleared the table, and the resident walked to get his medications. The report indicated staff had no choking concerns, no concern for injury, and the resident had no recent illnesses, or head strikes. The report indicated emergency responders stopped CPR when staff provided valid do not resuscitated (DNR) paperwork.

During investigative interviews, multiple staff members stated the resident had put non-food items in his mouth, but never choked before.

During an interview, a family member stated she did not believe the facility could have done anything different to change the outcome of the incident.

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

Action taken by facility:
The facility conducted an investigation, provided additional training to staff on responding to emergencies and monitoring residents at mealtime.

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
	37869	A. BUILDING: _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

(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 July 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL378693725C/#HL378693462M. No correction orders are issued.	0 000		