Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378695121M
Compliance #: HL378696861C

Date Concluded: October 15, 2024

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

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

Evaluator's Name:
Maerin Renee, 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 staff failed to appropriately supervise residents to protect their health and safety. A resident-to-resident altercation occurred (between the resident and a peer). The resident was hospitalized and diagnosed with subdural hematoma and a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident and the resident's peer argued when the resident wandered near her peer's room. Neither resident had a history of physical aggression toward each other or toward other residents of the facility, and their plan of care was being followed. Facility staff could not have foreseen the incident would occur.

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, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's services included help with mobility, ambulation, meals, medication administration, housekeeping, laundry, and activities of daily living. The resident's assessment indicated the resident was susceptible to physical abuse, lacked community orientation skills, and was unable to deal with verbally/physically aggressive residents.

The facility sentinel event document indicated the resident was found on the floor in the memory care hallway. The incident was initially determined to be an unwitnessed fall. Staff called 911 and the resident was admitted to the hospital. A computed tomography (CT) scan indicated the resident had a subdural hematoma. The resident complained of left hip pain, and an x-ray was initially negative for fractures. After three days, the resident continued to complain of left hip pain, and a CT scan revealed a left femoral neck fracture. The resident was discharged from the hospital 13 days after admission to a transitional care unit. Facility leadership viewed recorded camera footage of the night the resident fell and discovered the resident appeared to have been pushed by a peer outside the peer's room. As a result, the resident fell to the floor. Staff found the resident lying on the floor four minutes later.

The recorded camera footage showed the resident in the memory care unit hallway standing outside her peer's door. The resident's peer was standing just inside the door, with her left hand holding the resident's right hand. The resident's peer stepped out of her room and took hold of the resident's lower right arm with her right hand. The resident's peer ungripped her left hand from the resident's lower right arm and moved her left hand to the resident's right upper arm. At that point, the resident lost her balance and began to fall. As the resident fell to the floor, the resident's peer lost her balance, falling forward nearly onto the floor. The resident's peer was able to place both her hands on the floor to steady herself and stand back up. The resident's peer turned around and walked back into her room as the resident lay on the floor.

Progress notes and incident reports indicated the resident, and her peer had no known aggressive interactions prior to this incident, and neither had displayed physical aggression toward other residents. The resident's peer had no memory of the interaction with the resident.

Physical therapy (PT) progress notes documented during the resident's TCU stay indicated the resident wandered in the hallway, looking in another patient's room and required redirection to return to her room. PT facilitated gait training without an assistive device to increase the resident's ambulation tolerance. The resident ambulated 300 feet but was easily distracted.

A sentinel event document indicated three days after the resident returned from the TCU the resident was sitting in her wheelchair in the memory care dining room. She got out of the wheelchair and began to walk across the dining room. The resident tried to navigate around a pillar, lost her balance, and fell onto her right side, hitting her head on the wall. The resident said her head hurt.

Camera footage revealed the resident sitting in the lower right corner of the screen. The resident was sitting in her wheelchair and wheeled herself a short distance before she stood up. The resident was wearing slip-on sneakers. The resident walked along the cafeteria with a slow, shuffling gate, hands in her pockets. The resident walked past a pillar at the entrance of the cafeteria. A second pillar was a short distance away, but there was a walker parked near it. When walking between the second pillar and the walker, the resident got tripped up on her feet and fell to the floor onto her right side. It appeared the resident hit her head on the wall as she fell. As the resident lay on the floor, two staff members immediately ran to her side. The two staff members briefly assessed her before the first staff member walked away and the second staff member went to get the resident's wheelchair. The first staff member returned, wheeling another resident into the living room area. Both staff members appeared to try to manage the scene as residents gathered in the area. The first staff member then stayed with the resident, while the second staff member left the memory care unit. The video clip ended.

Progress notes indicated staff assessed the resident and called 911. The resident was admitted to the hospital and received surgery on her right hip. The resident passed away in the hospital three days after admission.

The resident's hospital record indicated she was diagnosed with a scattered subarachnoid hemorrhage, subdural hematoma, and closed fracture of right hip. The resident underwent a surgical hip repair. After the surgery, the resident's blood pressure lowered, and a family member elected to transition the resident to comfort cares.

The medical examiner report indicated the resident died from complications of multiple blunt force injuries due to falls. The manner of death was documented as homicide.

When interviewed, multiple staff members stated both the resident and her peer were pleasant and prone to wandering. The resident's peer would verbally express frustration, but neither resident had displayed physical aggression toward each other or other residents prior to the incident. When the resident first fell, facility staff thought it was an unwitnessed fall and triaged it accordingly. Staff found the resident minutes after she fell and called 911. When the hospital informed the facility of the extent of the resident's injuries, the facility leaders reviewed camera footage and discovered the resident's fall was precipitated by the confrontation between the resident and her peer. The resident appeared to wander toward her peer's room, and the peer attempted to push her away. As a result, the resident fell to the floor, and her peer nearly fell as well. This came as a surprise to staff, as neither resident had been known to interact with each other prior to this incident, nor had either expressed physical aggression.

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 provided supplemental staff training on how to intervene and recognize potential aggressive behavior. Staff continued to supervise resident-to-resident interactions and intervene when needed. A lock was placed on the resident’s peer’s door for her to use when she wanted to help keep residents from wandering into her room.

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 09/23/2024

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 September 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL378696861C/#HL378695121M. No correction orders are issued.	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.	