Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306343120M
Compliance #: HL306343082C

Date Concluded: September 18, 2024

Name, Address, and County of Licensee Investigated:
Brookdale West St. Paul Assisted Living
305 Thompson Ave East
West St. Paul, MN 55118
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela, 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 identify a change in condition. The resident was transported to the hospital with stool covering her buttocks and diagnosed with a urinary tract infection (UTI), sepsis (infection in the bloodstream), and two chronic subdural hematomas (brain bleeds) on each side of the head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's plan of care was followed at the time of the incident. Due to a lack of information and documentation, it was unable to be determined if there was a delay in care; however, when a change in condition was observed, facility staff contacted emergency medical services (EMS) and transported the resident to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case manager.

The investigation included review of the resident record(s), death record, hospital records, facility documentation, employee files, and facility policies and procedures. Also, the investigator observed the facility environment, staff to resident interactions, and medication and treatment administration.

The resident resided in an assisted living facility. The resident's diagnoses included acute encephalopathy (brain is affected by infection or toxin), history of deep vein thrombosis (blood clots), incontinence, and depression. The resident's assessment indicated the resident's cognition was intact, could communicate their needs when given the time to find the right words. The resident was independent with meals, transfers, and mobility with the use of a walker. The resident was independent with toileting but required reminders to change incontinence products. The resident's service plan included nightly safety checks.

The resident had a history of refusing showers and staff assistance with changing overnight incontinent products. The resident also had difficulty sleeping at night, slept throughout the day in her recliner, and was difficult to arouse for cares due to sleepiness.

The resident's medical record from several days prior to the resident's hospitalization, lacked documentation of cares provided to the resident and included no note of a change in the resident's condition. However, documentation from the day of the incident indicated the resident had not felt well for a couple of days, had vomited the night before, was short of breath, and lethargic (fatigued).

Hospital records indicated the resident smelled of urine and had stool on the buttocks area upon arrival to the emergency department. Family reported to hospital staff that the resident had a recent decline in condition with noted changes in memory and slept several hours during the day. The resident was diagnosed with a urinary tract infection (UTI), sepsis (systemic infection) and two chronic, inoperable, subdural hematomas (brain bleed) and admitted to the hospital. The resident discharged from the hospital on hospice care and died a short time later.

During an interview, an unlicensed staff member stated the resident usually took medications without refusal, but a few days prior to being hospitalized, the resident needed more encouragement to take prescribed medications. On the day the resident was sent to the hospital, the staff member noticed the resident was weak and could not sit up independently. The staff member reported the resident's change in condition to the nurse who assessed the resident and called 911 to have the resident transported to the hospital.

During an interview, the resident's family stated they spoke with the resident daily on the phone, visited the resident once per week and assisted with the resident's shower. The family member stated the resident refused to use the call pendant and refused assistance with cares.

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:
When the resident had a change in condition, the facility nurse completed an assessment, called 911 and the resident was transported to the hospital for evaluation.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30634	A. BUILDING: ______ B. WING ______	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST ST PAUL AL	**305 THOMPSON AVENUE EAST WEST SAINT PAUL, MN 55118**

(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 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306343082C/#HL306343120M. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE