Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202316523M
Compliance #: HL202319738C

Date Concluded: December 27, 2024

Name, Address, and County of Licensee Investigated:
Brightondale Senior Living
2700 Rice Creek Rd
New Brighton MN 55112
Ramsey County

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

Evaluator's Name: Maggie Regnier
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 the facility did not identify a stroke that was occurring.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did suffer a catastrophic stroke, the facility staff acted timely and appropriately as symptoms arose.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the facility triage company and family members. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, visitors and residents.

The resident resided in an assisted living facility. The resident's diagnoses included epilepsy, high blood pressure, and history of stroke. The resident's service plan included assistance with medication management and bathing. The resident's assessment indicated she was mostly independent and able to make her own decisions.

The progress notes indicated one morning the resident said she did not feel well and did not want to take her medications. Over the course of a short time, the facility continued to monitor the resident. The resident's symptoms worsened, and the facility sent her to the hospital.

- At approximately 7:30 AM, an unlicensed caregiver called the triage nurse to inform the nurse the resident did not want to take her medications and reported not feeling well with some nausea. The triage nurse advised the caregiver to obtain the residents vital signs and call the triage nurse back. About 15 minutes later the caregiver called the triage nurse with the resident's vital signs which indicated a slightly elevated blood pressure. The triage nurse advised the caregiver to recheck the blood pressure in one hour and offer saltines for her nausea.

- At approximately 8:15 AM, the resident had an emesis and reported feeling miserable. The resident self-administered an antacid. The caregiver rechecked the resident's vital signs and found the blood pressure still elevated but lower than the previous check. The triage nurse was called and, while hospitalization was considered, the decision was made to see if the antacid would help and advised the caregiver to call back in one hour with an update.

- At approximately 8:45 AM, the resident was lying in bed when a visitor approached her, and the resident turned over and slid to the floor. The resident denied hitting her head and denied any pain or bruises from the fall. The caregiver assisted the resident back to bed and called the triage nurse.

- At approximately 9:10 AM, the resident vital signs were taken and showed the blood pressure was still trending down but still not in the normal range while the resident still complained of nausea. The triage nurse advised to offer crackers/toast and ginger ale and or 7-up and update if symptoms continued.

- At approximately 10:15 AM, the caregivers checked on the resident and found the resident with a change that includes slowness to respond and slurred speech. Triage nurse was updated, who advised to call 911 and the facility send the resident to the hospital.

The next morning, the resident passed away. The death record indicated the resident had a catastrophic intracranial hemorrhage.

During an interview, a manager stated the facilities unlicensed caregiver acted accordingly to the facility's policy when she repeatedly called the triage nurse with updates.

During an interview, the triage nurse stated she and the unlicensed caregivers continued to monitor the resident's nausea and one episode of emesis but tried addressing those symptoms before sending her to the hospital. The resident did not exhibit symptoms like pain not even a headache.

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

Action taken by facility:
The facility provided the unlicensed caregiver training for when to call the triage nurse.

Action taken by the Minnesota Department of Health:
No further action 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
	20231	A. BUILDING: _____ B. WING _____	C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	2700 RICE CREEK ROAD NEW BRIGHTON, MN 55112

(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 December 17,2024, the Minnesota Department of Health initiated an investigation of complaint #HL202319738C/#HL202316523M. No correction orders are issued.	0 000		