Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL306298903M
Compliance Project: HL306296882C

Date Concluded: April 29, 2025

Name, Address, and County of Licensee Investigated:
Walker Methodist Westwood 1
1 Thompson Ave W
St. Paul, MN 55118
Dakota County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 "I'm ok" checks were not completed, and the resident was found deceased in his room.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident was not receiving services from the facility. Although the "I'm OK" service offered by the facility was an optional service, it was not based on an individualized resident comprehensive assessment. With no services, the facility was not required to complete an assessment to determine if the supportive service was necessary nor an opportunity to discover identifiable risks.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, facility internal investigation, staff schedules, law enforcement report, and related facility policy and procedures. Also, the

investigation included an onsite visit, observations and interactions between residents and facility staff members.

The resident resided in an assisted living facility, however the lease agreement only included the monthly renting of the apartment, at the time the lease was signed, resident declined all services within the facility.

The resident did choose to participate in daily “I’m ok” checks. These daily checks were provided on a complimentary basis by the facility for residents that did not receive assisted living services from the facility.

One Monday morning, facility staff member #1 was completing the daily “I’m OK” program, when the resident did not notify the facility staff that he was OK, the facility staff member then attempted to call the resident, and the call was directed to voicemail. The facility staff member then went to the resident’s apartment to complete a physical check, where the resident was found deceased in his apartment.

During an interview, facility staff member #2 stated she worked the 2 days prior, but could not recall if she called the resident or if a room check was made. During the same interview she stated the “I’m OK” process did not require documentation of which residents received a phone call or a physical room check. Facility staff member #2 stated all staff has been retrained on the “I’m OK” policy and now documentation is required for the process and the documentation is retained by the manager.

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

Action taken by facility: Review of "I'm OK" program, changes made to include documentation of daily processes and retention of records. All staff retrained on changes to policy and procedure.

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
	30629	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD I	1 THOMPSON AVENUE WEST 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 April 8, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306296882C/#HL306298903M. No correction orders are issued.	0 000		