Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306917302M
Compliance #: HL306912420C

Date Concluded: March 4, 2025

Name, Address, and County of Licensee Investigated:
Brookdale Eden Prairie
7513 Mitchell Road
Eden Prairie, Minnesota 55344
Hennepin County

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

Evaluator's Name: Nicole Myslicki, 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 the resident fell several times in about one week. The resident sustained broken ribs and vertebrae.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility sent the resident to the hospital for evaluation after the first fall when they suspected injury, and again when the resident's agitation persisted for about a week. Facility staff administered as needed medications and communicated with the family and provider.

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, staff schedules, and related facility policy and procedures. Also, the investigator observed transfers and assistance with walking.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with toileting, walking, bathing, and medication administration. The plan also indicated the resident demonstrated anxious, disruptive, or obsessive behaviors and required additional attention and redirection at times. The resident's assessment indicated he needed help going to and from the dining room and activities, as well as wandering redirection.

A progress note indicated a nurse held a care conference with the resident's family members one day before the resident's falls. The note indicated they discussed the resident's behaviors over the previous weekend, including being agitated and impulsive and needing one-to-one supervision for safety reasons. The nurse explained the facility services did not include one-to-one service and suggested family hire a companion to sit with and monitor him for safety. A family member stated she could not afford that, so the nurse instructed family to provide the one-to-one service when agitated. Family agreed to provide the one-to-one service.

An incident report indicated the resident fell one morning. The resident sustained a cut to his elbow.

A progress note indicated staff found the resident on the floor near his bed. The resident reported he hit his head, and he had been experiencing pain. Staff obtained his vitals and sent the resident to the hospital after a nursing assessment. The note indicated the resident had been agitated prior to the fall, getting up on his own even though he required assistance of one staff member. The resident had also been noncompliant, impulsive, and at times unable to follow verbal cues and directions.

The resident's after visit summary (AVS) from the hospital indicated the resident had a closed head injury and skin tear of the left elbow from the fall. The hospital completed imaging of part of the resident's spine, his head, and his elbow.

A progress note indicated the resident returned from the hospital within about eight hours after the fall. Another progress note indicated family requested an as needed medication to help with the resident's agitation during dinner.

A second incident report indicated the resident fell about twelve hours after the first fall. The resident had no apparent injury after the unwitnessed fall.

The resident's record included several progress notes indicating the resident presented with agitation prior to and after his falls. Notes indicated the resident yelled, tried getting up and walking on his own, and at times became combative or aggressive. Notes also indicated the facility staff gave as needed medications to help with anxiety and agitation, reached out to the provider, and tried redirection.

A progress note indicated the resident had been agitated and yelling for help most of the morning one day. The resident could not identify pain or explain what was wrong. Staff called 911 and sent him out for evaluation, then notified the family.

A facility internal investigation included a summary timeline of events and behaviors from the resident. The resident became agitated and began screaming in the dining room the day he admitted to the facility. The resident's family member stayed with the resident over the weekend. During the first few days of admission, the resident walked around in the dining room without clothing and had other behaviors of agitation, shouting, difficult to provide cares and attempting elopement. The next morning, approximately one week after admission, the resident fell in his room. He went to the emergency department (ED) and returned mid-afternoon. About twelve hours after the first fall, the resident had an unwitnessed fall in the living room with no apparent injury.

During the days after the fall, the resident continued trying to walk unassisted, had increased anxiety with screaming and agitation with cares. On the fourth day, the resident had been screaming often, complaining of pain in his shoulder and side. The resident's family visited much of the weekend. On the fifth day, the resident had been observed in the dining room on his hands and knees, without clothing, scaring other residents. The same day, the resident's family assisted him to bed with an unlicensed personnel (ULP) and transfer belt. The resident went to his knees, and the ULP called for assistance from another ULP. Two days later, the resident screamed, did not want to get dressed, and needed three staff members to get ready. Staff called emergency medical services (EMS) and the resident went to the hospital. The next day, the hospital notified the facility the resident had fractured ribs and back. The investigation indicated the resident's family believed the injuries occurred during his first fall. While at the facility, family asked for staff to get the resident up and get him to the dining room, while the resident appeared resistant and agitated, yelling and requiring two to three staff for transfers.

The resident's hospital record indicated he presented to the ED due to worsening agitation and concern for pain with a history of falling a week prior. The ED completed imaging and found two broken ribs and two age-indeterminate mild compression deformities of the spine. A hospital provider noted the spine fractures had an acute or subacute appearance. During the hospitalization, the resident appeared agitated, yelling out, pulling at his intravenous (IV) access, and required one-to-one staffing at his bedside. The hospital record indicated the resident required several medications to help his agitation. The resident's delirium had most likely been secondary to pain, although other contributing factors included medications, poor nutritional status, and a previous stroke. The resident had been struggling with increasing agitation and delirium following the stroke a couple of months prior. The resident's hospital diagnoses included altered mental status, agitation due to dementia, and fractures of the spine and ribs. The record indicated the resident admitted to hospice and died in the hospital.

The resident's death record identified the resident's cause of death as terminal delirium. The death record did not identify the resident's broken spine or ribs as contributing to death.

During an interview, a nurse stated the resident fell twice in one day. After the first fall, the facility sent him in for evaluation. He did not have any apparent injury with the second fall from him getting up without help. Facility staff tried redirection, keeping him in public spaces to keep an eye on him, utilized as needed medication, got an order for increasing a medication, and encouraged him to gain strength, walking as much as possible. The resident had an order for therapy, but therapy determined they would not do therapy with him because he would not follow their plan. Prior to the resident admitting to the hospital and discharging from the facility, the nurse wanted him to be seen by the medical provider and could tell something seemed wrong, but family objected. The nurse stated although his prior facility did not describe any behaviors, the resident presented with behaviors after admitting to the facility which became increasingly more difficult to care for. They had a conversation with the resident's family member, explaining he needed one-to-one monitoring which the facility did not provide. Family declined but spent a lot of time at the facility.

During an interview, the licensed assisted living director (LALD) stated the resident had been screaming a lot from the day he arrived. The family spent a lot of time at the facility. At one point, the LALD encouraged family to bring the resident in to be seen by a physician, but they declined. The day they sent the resident into the hospital, three staff members were needed to assist him with cares. It seemed unclear if the resident had been in pain because of how he acted since admitting to the facility.

During an interview, a family member stated the resident lived at the facility for less than two weeks. Four days after admitting to the facility, the resident fell in the morning and went to the hospital. The hospital did imaging of his arm and head, then discharged him back to the facility in the afternoon. That evening, the resident fell again. The family member visited the resident the next day, and he seemed to be okay, but he did start yelling. Two days later, the family member arrived prior to lunch and helped him eat, staying for about six hours. He began yelling and screaming and laid in bed a lot of the day. When the resident started yelling that day, he did not stop until he went to the hospital four days later. Two or three days before going to the hospital, the resident had been yelling so much, the family member had to take him out of the dining room and feed him somewhere else due to disrupting the other residents. When the resident admitted to the hospital, they found he had broken ribs and spine. Hospital staff stated the resident would not heal well from surgery, so they opted not to do surgery on his spine and instead made him comfortable. One week after admitting to the hospital, the resident died. The family member stated they felt the facility's negligence contributed to the resident's death.

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. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed an internal investigation. The nurse assessed the resident after the falls. The facility continued to provide cares as the resident was willing and administer medications. The facility staff sent the resident to the hospital twice.

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
	30691	A. BUILDING: _____ B. WING _____	C 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDEN PRAIRIE	7513 MITCHELL ROAD EDEN PRAIRIE, MN 55344

(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 January 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306912420C/#HL306917302M. No correction orders are issued.	0 000		