Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322168684M
Compliance #: HL322166284C

Date Concluded: March 31, 2025

Name, Address, and County of Licensee Investigated:
Walker Methodist Plaza Gardens
100 Monroe Street 337
Anoka, MN 55303
Anoka County

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

Evaluator's Name: Katherine Barnhardt, RN, Special Investigator

Finding: Substantiated, facility responsibility

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 failed to provide supervision, interventions or education to prevent the resident's fall that resulted in death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility had knowledge of the resident's fall history. The resident's spouse had diagnoses of dementia, falls and required a Hoyer (mechanical lift) for mobility. The resident's spouse was unable to provide any type of assistance to the resident. The facility staff would often see family transport the resident from a specialized care area to another area of the facility where significantly less staff supervision was present. The facility failed to provide education or interventions to prevent the resident from being left unsupervised.

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(s), death record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, 911 transcripts, related facility policy and procedures. Also, the investigator observed facility staff provide direct cares.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, tremors and muscle weakness. The resident's service plan included medication management, assistance with meal escorts, dressing, toileting, safety checks, ambulation and transfers with a mechanical lift (device used to transfer residents unable to stand or transfer themselves). The resident's assessment indicated the resident had cognitive impairment, was impulsive, chair bound, required staff assistance for mobility and was unable to use a call pendant to alert staff of needs.

The residents record indicated the resident received blood thinning medication daily and had a history of falls. The resident moved from the facility's secured memory care to a smaller specialized care area due to impulsiveness and the resident's fall history. The specialized area was separated from the rest of the facility by a closed door and located on the third floor of the building. The specialized area included five apartments grouped close together with common living and dining space to ensure closer observation of residents by facility staff.

The residents scheduled services record indicated the resident had services scheduled nearly every hour throughout the day and every two-hour safety checks at night. A completed service record indicated a meal escort back to the resident's room and a toileting assist scheduled for 6:00 p.m. and 6:30 p.m. respectively, were signed off by unlicensed staff at 6:20 p.m. the evening of the incident. The resident was not present in the specialized care area at the time unlicensed staff signed off evening tasks.

A time stamped video indicated a family member signed in to the facility at 5:25 p.m. and signed out of the facility at 6:10 p.m. While at the facility, the family member transferred the resident out of the specialized care area and to a spouse's room located in another area of the facility on the third floor. The resident was left unsupervised when the family member left the facility.

The resident's progress notes indicated it was routine for family members to take the resident out of the specialized area to visit a spouse. Progress notes indicated the family member left the facility a short time after arrival and left the resident in the spouse's room. Progress notes indicated unlicensed staff were scheduled to administer the resident's evening medications and were unable to locate the resident. Several unlicensed staff searched the building, opened the spouse's room door, saw a dark room but did not see the resident, and continued searching the rest of the building. Unlicensed staff phoned a family member and were informed the resident was left in the spouse's room next to the spouse's bed in her wheelchair. Unlicensed staff

returned to the spouse's room, turned on lights and located the resident face down in the springs of a hospital bed with severe injuries. Unlicensed staff notified on-call triage for a medical emergency.

The residents progress notes indicated an unlicensed staff had called triage on-call, reported the resident was found in a spouse's apartment and had fallen face first into a hospital bed. The unlicensed staff reported head trauma and bleeding and were instructed to call 911. Progress notes indicated 911 was called. Law enforcement and emergency medical services arrived at the facility and life-saving measures were started until the resident's resuscitation status was verified. The progress notes indicated unlicensed staff called triage back and reported the resident had died.

The law enforcement report indicated law enforcement was notified of a resident found unconscious and breathing. The report indicated when officers arrived the resident was not breathing, and cardiopulmonary resuscitation (CPR) was started. The report indicated a short time after arrival resuscitation status was verified and CPR was stopped. The resident was declared deceased.

The facility's internal investigation indicated unlicensed staff had observed a family member wheel the resident out of the specialized area and this was not unusual. Several hours later, unlicensed staff looked for the resident to administer evening medications and were unable to locate the resident. The internal investigation indicated several staff searched the building and at one point opened the door to the spouse's room, however, did not see the resident in the dark room. The internal investigation indicated the resident's family had been called and were told the resident was left in the spouse's room next to the bed. Unlicensed staff returned to the spouse's room, turned on lights and found the resident face down on the spouse's hospital bed with head and facial injuries. The internal investigation indicated on-call triage and emergency medical services were called to the facility and emergency care was provided, however, the resident's code status indicated no resuscitation, and the resident passed away.

During interview, unlicensed personnel stated a coworker had come to her area on the second floor and asked if she had seen the third-floor resident because it was the resident's medication time. The unlicensed personnel told the coworker she had not seen the resident and both unlicensed personnel started looking for the resident. The unlicensed personnel asked the coworker if she had looked in the spouse's room because it was typical for family to come in the evening and transport the resident to the spouse's room for a visit. The coworker stated she had checked the spouse's room and did not find the resident; however, two other unlicensed personnel made the decision to recheck the spouse's room while other unlicensed personnel continued the building search. The unlicensed personnel stated the two staff that went to the spouse's room found the resident on the floor with her face in the bed and bleeding. The unlicensed personnel stated on-call was notified and unlicensed personnel were directed to call 911 and 911 transferred the call to paramedics. The paramedics directed unlicensed personnel to roll the resident over on her back and start chest compressions, which she did until

emergency services arrived on site and directed no resuscitation. The unlicensed personnel stated she had worked at the facility for a year and did not recall any communication or direction on the plan of care directing unlicensed personnel to check on the resident while the resident was out of the specialized care area or changes to the resident's services related to supervision of the resident.

During interview, another unlicensed personnel stated the resident resided in the specialty unit because she was a high fall risk and specialty unit residents were closely monitored. Unlicensed personnel stated the resident was dependent on staff for total care and did not have the cognitive ability to utilize a call pendant. Unlicensed personnel stated staff communicated with most other families if a resident was taken out of the specialty unit, however, communication with the resident's family had not occurred. Unlicensed personnel stated she was assisting another resident when she saw the resident's family member transport the resident out of the specialty unit, but did not approach them because it was the resident's family and wasn't concerned. Unlicensed personnel stated the resident was not able to stand without the support of a mechanical lift and was dependent on unlicensed personnel to assist with all activities of daily living. The unlicensed personnel stated she had not seen the resident's family member after that and started looking for the resident when evening medications were scheduled. Unlicensed personnel stated the resident was found in her spouse's room face down in the hospital bed springs and 911 was called.

During interview, licensed staff stated the resident had resided in the facility's secured memory care unit, however, due to the resident's history of impulsiveness and falls, the resident was moved to a specialized care area that had a smaller ratio of residents and staff were able to engage more often with the resident. Licensed staff stated unlicensed staff were able to keep a closer eye on the resident and have more hands-on interactions. Licensed staff stated it was not uncommon for the resident's family to transport her from the specialized care area to another area of the facility for visitations with her spouse and family would return the resident when they left the facility. Licensed staff stated on this day it was between 5:30 p.m. and 5:45 p.m. when family transported the resident out of the specialized care area. Licensed staff stated the resident's evening services were signed off at 6:20 p.m., when the resident would not have been present in the specialized care area. Licensed staff stated unlicensed staff had not signed off the tasks in real-time making it difficult to know how much time had passed since staff had seen the resident. Licensed staff stated the family typically returned the resident to the specialized care area before leaving the facility, however, on this day the resident was not returned, and staff were unaware family left the facility. Licensed staff stated supervision of the resident was based on scheduled service times and the facility did not provide one to one service. Licensed staff stated the resident would be safe unsupervised for a short period of time, however, not for a long period of time. Licensed staff stated a short period of time would be no longer than the time between scheduled services. Licensed staff stated she was not aware of conversations or communications with the resident's family about leaving the resident unsupervised and there were no coordinated or written interventions in place between the resident's family and facility staff.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When unlicensed staff located the injured resident, unlicensed staff notified on-call triage and 911.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Anoka County Attorney
Anoka City Attorney
Anoka Police Department
Anoka Sheriff’s Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32216	A. BUILDING: _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLAZA GARDENS	100 MONROE STREET ANOKA, MN 55303

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL322168684M/#HL322166284C On March 3, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 75 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL322168684M/#HL322166284C, tag identification 0510 and 2360.	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32216	A. BUILDING: _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLAZA GARDENS	100 MONROE STREET ANOKA, MN 55303

(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
0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP)-C when personal cares were provided. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on September 3, 2024, to provide direct cares to licensee's residents. ULP-C's training competencies to include infection control were signed off by the licensee's registered nurse on September 3, 2024.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32216	A. BUILDING: _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLAZA GARDENS	100 MONROE STREET ANOKA, MN 55303

(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
0 510	Continued From page 2 On March 3, 2025, at 10:35 a.m., the investigator observed ULP-C and clinical nurse supervisor (CNS)-A transfer R1 with a Hoyer (mechanical lift utilizing a body sling) from R1's recliner to a hospital bed to complete personal hygiene cares. CNS-A exited the room and ULP-C put on purple disposable gloves. ULP-C removed R1's soiled brief, utilized disposable wiping cloths for incontinence cares, applied barrier cream to R1's buttocks and placed a clean tab brief on R1. During the process of incontinence cares, with the same gloves on, ULP-C flipped long braided hair from the front of her body to the back of her body several times. ULP-C went to R1's closet, retrieved clean clothes and dressed R1 while wearing the gloves used for incontinence cares. ULP-C removed the gloves, disposed of them into a small garbage bag, tied off the bag, exited the room, walked to a separate maintenance room, opened the door with knob used by all staff and disposed of the garbage bag in a receptacle. ULP-C walked back to a main living space and utilized a sink located in a commonly shared kitchenette to wash her hands. On March 3, 2025, at 10:57 a.m., the investigator asked ULP-C if she was taught infection control and ULP-C stated "yes, we are taught that, that was my fault". On March 5, 2025, at 10:32 a.m., CNS-A stated staff are taught infection control and it is the expectation that ULP's change gloves between dirty and clean tasks and wash hands between going in and out of resident rooms. The licensee's Infection Control Program policy revised January 2025 indicated staff training and competency components of licensee's infection	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32216	A. BUILDING: _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLAZA GARDENS	100 MONROE STREET ANOKA, MN 55303

(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
0 510	Continued From page 3 control program would include oversight planning, organizing, implementing, operating, monitoring and maintaining all elements of the infection control program and ensure the community's interdisciplinary team is involved in infection control and prevention. The policy indicated licensee's registered nurse (RN) would regularly train all staff members on proper hand hygiene, infection control policies and would regularly assess staff for knowledge and competency of infection control practices. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	0 510		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		