DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201074985M
Compliance #: HL201078579C

Date Concluded: August 10, 2023

Name, Address, and County of Licensee Investigated:
Landings of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN 55345
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katie Germann, 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 a resident when staff did not provide cares or safety checks for over eight hours. The resident vomited blood, aspirated (breathed the vomit into her lungs), and was transported to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was taken over by new ownership at midnight the night of the incident. The resident vomited blood three times during the night. Staff did not check on the resident according to the resident's plan of care. The resident's family member found the resident lying in bed the next morning with her face covered in vomit. The family member contacted 911 and the resident was transported to the hospital and was diagnosed with aspiration.

The investigator conducted interviews with facility administrative staff and the resident's family member. The investigation included review of medical records, hospital records, facility policies and procedures, the facility incident report, staff schedules and call light records.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis. The residents plan of care indicated the resident required one staff for transferring out of bed, and staff were directed to check on the resident at 2:00 a.m. and 6:00 a.m.

A facility incident report indicated the resident's family member called the facility and told them the resident was found in her room covered in vomit. The report indicated the resident was transported via ambulance to the hospital.

The hospital notes indicated the resident began vomiting blood while lying in bed the previous night, but no one responded to the residents call light or checked on the resident during the night. When emergency medical services arrived at the facility the resident oxygen saturation was 87-88% on 6 liters of oxygen. The resident aspirated on the vomit, which caused pneumonia and a COPD exacerbation leading to respiratory failure. The resident was treated in the hospital for eight days and discharged to a transitional care unit for ongoing skilled nursing care.

During an interview, the resident's family member stated she arrived at the facility at approximately 8:15 a.m. The resident was lying in bed and had coffee colored vomit all over her face and chest. The resident told the family member she called for staff assistance, but nobody came. The family member called 911. The family member stated she never saw any staff at the facility, even after the ambulance arrived and transported the resident out of the facility.

During an interview, the facility administrator stated the current management took ownership of the facility at midnight the overnight shift of the incident. The previous management staff did a handover of the residents' service plans with the new staff on the overnight shift. The administrator stated because the resident was due to discharge from the facility the next day, the resident had no service plan and staff did not provide any cares or safety checks for the resident on the overnight shift.

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

Action taken by facility:
No action taken.

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
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: #HL201078579C/#HL201074985M #HL201079102C On July 18, 2023, 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 65 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL201078579C/#HL201074985M, tag identification 0320, 0900, 2310, and 2360. The following correction order is issued for #HL201079102C, tag identification 0900	0 000		
0 320 SS=D	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive	0 320		

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0 320	Continued From page 1 state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee did not provide requested resident records for one of one resident (R1) during a complaint investigation. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: On July 18, 2023, at 8:33 a.m., the Minnesota	0 320		

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0 320	Continued From page 2 Department of Health (MDH) Surveyor contacted the facility's Licensed Assisted Living Director (LALD)-A via email and requested R1's facesheet, assessments, hospital notes, progress notes, service plan, care plan, physician orders, individual abuse prevention plan, medication administration record (MAR), treatment administration record (TAR), progress notes, incident reports, and documention of services provided to R1 by facility staff. On July 19, 2023, at 8:13 a.m., LALD-A emailed one progress note and an incident report to the MDH surveyor. On August 2, 2023 at 1:50 p.m., LALD-A sent an email to the MDH surveyor indicating, "R1 did not have a care plan or service plan due to her moving out the day of change of ownership and not planning on admitting with new management". During interview on August 3, 2023, at 9:00 a.m., licensed assistant living director (LALD)-A stated the current management took ownership of the facility at 12:00 a.m. on February 1, 2023. LALD-A stated because R1 was due to discharge to another facility later the same day, R1 had no assessments completed, no care plan, service plan, signed physician orders, MAR, TAR, or documention of services provided by facility staff. LALD-A stated the old management took all of the residents record with them. (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.	0 320		

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0 320	Continued From page 3 (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 320		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract	0 900		

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0 900	Continued From page 4 and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to execute an assisted living contract for two residents (R1 and R2) with records reviewed. This had potential to affect all thirty-nine (39) residents receiving assisted living services at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 the potential to affect a large portion or all of the clients). The findings include: R1 R1's facility medical records were requested and not provided.	0 900		

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0 900	Continued From page 5 R1's hospital records dated February 6, 2023, indicated R1 was receiving assistance with walking, bathing, dressing, medications, meals, housekeeping, and laundry at the assisted living facility. R1's medical diagnoses included rheumatoid arthritis and chronic obstructive pulmonary disease. R1 was at an increased risk of bleeding due to using Warfarin (a blood thinner). R2 R2's service plan dated January 31, 2023, indicated R2's diagnoses included bipolar disorder and mild cognitive impairment. R2 received assistance with medications, transportation, housekeeping, laundry, and meals. Nursing notes dated February 1, 2023, indicated R2 signed his lease and service plan during the day shift on February 1, 2023. During interview on August 3, 2023, at 9:00 a.m., the licensed assisted living director (LALD)-A stated the current management took over ownership of the facility on February 1, 2023 at 12:00 a.m.. At the time of the change in ownership, there were 39 residents living at the facility. LALD-A confirmed prior to the new management taking over, there were no signed contracts in place with the residents currently residing in the facility. LALD-A stated the current management made arrangements with the existing residents to provide assessments and meet with residents and families starting at 6:00 a.m. on February 1, 2023. (a) An assisted living facility may not offer or provide housing or assisted living services to any	0 900		

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0 900	Continued From page 6 individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. A facility policy titled "Admissions" dated February 1, 2023, indicated, A RN must orient each person who will perform assisted living services to the client and the care services to be performed.	0 900		

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0 900	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 900		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R1), when staff failed to check on R1 according to the residents plan of care. The resident was found in bed by family covered in vomit. The resident was transported to the emergency room and diagnosed with aspiration. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1's facility medical record was requested and	02310		

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02310	Continued From page 8 not provided. R1's hospital record dated February 1, 2023, indicated R1's medical diagnoses include rheumatoid arthritis and chronic obstructive pulmonary disease. R1 was at an increased risk of bleeding due to taking Warfarin (a blood thinner). Hospital records dated February 6, 2023, indicated R1 was receiving assistance with walking, bathing, dressing, medications, meals, housekeeping, and laundry at the assisted living facility. A facility incident report dated February 1, 2023, indicated R1's family member called the facility and informed them R1 was found in her room covered in vomit. The report indicated R1 was transported to the hospital via ambulance on the morning of February 1, 2023. R1's hospital notes dated February 1, 2023, indicated emergency medical services (EMS) reported R1 began vomiting blood while she was lying in bed on the overnight hours of January 31, 2023, into the morning February 1, 2023. R1 reported no staff at the facility checked on her during the night. On the morning of February 1, 2023, R1's family member found R1 lying in her bed covered in bloody vomit and contacted EMS. Upon arrival to the facility, EMS found R1's oxygen saturation levels to be 87-88% on 6 liters of oxygen. R1 was treated for aspiration pneumonia and a gastrointestinal bleed at the hospital. Hospital notes indicate R1 was hospitalized for eight days and discharged to a transitional care unit for ongoing skilled nursing care.	02310		

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02310	Continued From page 9 During interview on August 1, 2023, at 2:00 p.m., R1's family member (FAM)-B stated she arrived at the facility on February 1, 2023, at approximately 8:15 a.m. R1 was lying in bed and had coffee colored vomit all over her face and chest. R1 told Fam-B she called staff for assistance, but nobody came all night. Fam-B called 911. Fam-B stated she never saw any staff at the facility, even after the ambulance arrived and transported R1 out of the facility. Fam-B stated R1's service plan included toileting and safety checks overnight at 2:00 a.m. and 6:00 a.m. During an interview on August 3, 2023, at 9:00 a.m., the licensed assisted living director (LALD)-A stated the current management took ownership of the facility at 12:00 a.m. on February 1, 2023. LALD-A stated because R1 was due to discharge to another facility later the same day, no service plan was provided by the previous owners for R1. Staff did not complete any cares or safety checks for R1 on the night of the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	02310		
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:	02360		

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02360	Continued From page 10 The facility failed to ensure one of one resident(s) 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		