

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201079286M
Compliance #: HL201076939C

Date Concluded: December 15, 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: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of the 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 the resident #1 was found unresponsive in resident #2's room.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. While resident #1 had a history of opioid abuse the facility had taken appropriate steps this including getting resident #1 a supply of Narcan. When resident #1 was found unresponsive in resident #2's room the facility responded appropriately to the emergency although the resident #1 was pronounced deceased. Resident #2 did not have a history of opioid overdose and left the facility for unrelated reasons. The relationship between the two residents was new and the facility was unaware of it.

The investigator conducted interviews with facility staff members, including administrative staff unlicensed staff. The investigation included review of both the resident's records, facility's

policies and procedures, incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident #1 resided in an assisted living facility. The resident's diagnoses included alcohol dependence and bipolar disorder. The resident's service plan included assist with mental health activities by cueing or standby assist.

The resident #2 resided in an assisted living facility. The resident's diagnoses included diabetes and cerebral infarction (stroke). The resident's service plan included assist with mental health activities by cueing or standby assist.

On the day resident #1 died, resident #2 reported to a staff member resident #1 was unresponsive in his room. The facility called emergency services were called, and despite all life-saving measures, resident #1 was pronounced dead.

Approximately one month prior, resident #1's update notes indicated resident #1 had an accidental overdose, and Narcan was administered by a staff member a month prior. The same documents indicated the facility added interventions including staff to monitor the resident during medication passing in the morning and evening, as well as when resident #1 was in common areas or returning from out in the community. The facility also instructed staff members to monitor any and all unfamiliar guests visiting the resident. The facility contacted resident #1's medical provider for a personal order for Narcan, which was placed in resident #1's room. Narcan was also available in the medication cart and the nurse's office.

During an interview, a management staff member stated resident #2 reported to a staff member resident #1 was in his room and would not wake up so the staff member called 911 and administered Narcan to resident #1. The management staff member stated she spoke with resident #2 who said resident #1 came to his room to "hang out" and that they did not use any drugs together. The management staff member stated residents #1 and #2 were not known to be friends prior to this event but she confirmed both residents were their own decision-makers, could come and go as they pleased, and were allowed to have guests to their private apartments. The management staff member stated resident #2 left the facility the same day for unrelated reasons.

During an interview, a staff member confirmed he did not know about the friendship between resident #1 and resident #2. He stated he checked on the residents throughout the day, approximately 8 to 10 times. The staff member also mentioned that the residents were freely roaming around the building.

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. Resident #1 was deceased. Attempts to reach resident #2 unsuccessful

Family/Responsible Party interviewed: No.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

No action required.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2023
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NAME OF PROVIDER OR SUPPLIER LANDINGS OF MINNETONKA	STREET ADDRESS, CITY, STATE, ZIP CODE 14505 MINNETONKA DRIVE MINNETONKA, MN 55345
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(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	<p>Initial Comments</p> <p>On November 8, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL201079286M/HL201076939C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____