Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205516382M
Compliance #: HL205519479C

Date Concluded: February 7, 2025

Name, Address, and County of Licensee Investigated:
Woodbury Senior Living Estates
2825 Woodlane Dr 207
Woodbury, MN 55125
Washington 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 the resident's wishes for cardiopulmonary resuscitation (CPR) was changed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident's code status (a clear communication for whether a person wants CPR or not) was changed upon discussion with the resident. Later the code status was updated again with input from the resident and the resident's family.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker, and the family member. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident to staff interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and depression. The resident's service plan included assistance with transfers using a mechanical lift, toileting and medication management and administration. The resident's assessment indicated the resident was able to understand and make her needs known, but confusion did vary over the course of the day. The resident was also wheelchair bound and was dependent on facility staff for mobility.

A concern arose the resident's advanced directive on whether she wanted cardio-pulmonary resuscitation performed while cognitively impaired and without consulting her family. The facility was conducting an audit to ensure it had the "code status" in each residents' room. It was discovered the facility did not have the resident's code status on file and the resident was asked what her wishes were regarding CPR.

A comprehensive nurse assessment completed during the same time the code status was changed indicated a BIMS (Brief Interview for Mental Status) score of 13, indicating the resident was cognitively intact on the date of the assessment. The form indicated the resident was oriented to the date, month and year when interviewed.

During an interview, a manager stated at time of the resident's assessment was completed. The manager stated the resident was cognitively intact and was residing in the memory care unit for the care of her spouse. The manager stated a facility employee had reviewed the code status with the resident, however in the meantime a new code status had been clarified when it came to their attention.

An additional concern arose regarding cleanliness of the environment were voiced as soiled items were found in a cluttered closet. While this concern was not specifically regarding maltreatment, the investigator inquired on this topic.

During the same interview, the manager stated housekeeping is provided weekly to the room, however daily the staff is to remove soiled garments and tidy the room as needed. The manager stated laundry is completed weekly and a portion is completed by each shift, so soiled laundry could be present in resident's rooms at other times during the week. The manager stated all managers were now adding checking closets as a part of their rounding.

During an interview, the nurse stated it was not uncommon in the memory care unit for other residents to enter rooms and randomly place items or rearrange items.

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.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20551	A. BUILDING: _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

(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 15, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL205519479C/#HL205516382M. No correction orders are issued.	0 000		