Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL29647001M **Date Concluded:** April 27, 2022
Compliance #: HL29647002C

The Waters of Edina
6300 Colonial Way
Edina, MN 55436
Hennepin County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The alleged perpetrator (AP), who is an unlicensed personnel (ULP), neglected the resident when the AP did not answer the resident's call light for 82 minutes.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the alleged perpetrator were responsible for the maltreatment. The resident activated her call pendant, but no staff members responded for 82 minutes. The AP's assignment included the resident, but the AP did not respond. The call pendant system alerted throughout the facility, but no other staff member responded until unlicensed personnel (ULP)-H arrived for the next shift.

The investigation included interviews with facility staff members, nursing staff, and the executive director. The investigation included an onsite visit, review of the resident's medical record, review of the facility incident reports, and call pendant logs. The investigation included a review of the resident's primary care provider notes and an interview with the resident's family member. The investigator reviewed the facility video recording of the memory care unit. The investigation included an interview with the AP.

The resident lived on the memory care unit with diagnoses including dementia, chronic obstructive pulmonary disease (COPD), depression, and anxiety. The resident's service plan indicated the resident required assistance with medication management, toileting, transfers, and walking. The resident's service plan also indicated the resident required continuous oxygen at 2 liters per minute (lpm). The same document indicated the resident required safety checks every two hours.

The facility's call pendant report indicated the resident activated her call pendant at 5:47 a.m. and continued to go off until manually turned off at 7:09 a.m. The call pendant went off for 82 minutes.

The resident's progress note from this same morning indicated a staff member entered the resident's room at 7:00 a.m. and found the resident laying in her recliner but not breathing and her oxygen on at 3 lpm. The facility called 911.

The resident's death record indicated she died the same morning due to chronic respiratory failure and COPD.

The facility's internal investigation included a Service Received report which indicated the AP documented providing services at 12:36 a.m., and 3:00 a.m., during the same night shift. However, the same document indicated the services were both documented at 7:04 a.m. and not the actual time of service. The internal investigation included an interview with the AP, who said her walkie talkie alerting her to the call pendant was working during the shift. The same document indicated the AP said she checked on the resident at 6:14 a.m. and she was doing okay.

A review of the facility's security footage with a view of the resident's hallway indicated the AP did not go into this area at 6:14 a.m.

The AP's training records indicated the AP received training regarding having a walkie on their person their entire shift to respond to the call pendant system, charting of services provided to the resident, and rounding for every resident every two hours.

The facility schedule indicated there were three ULPs and one licensed practical nurse (LPN) working the night shift. The facility's schedule for the night shift indicated the shift began at 11:00 p.m. and ended at 7:30 a.m. The same document indicated the AP was the staff member assigned to the resident's memory care unit.

During an interview, registered nurse (RN) stated the call pendant system sounds across walkies which staff members are to carry with them. The RN stated the pendant light will continue to repeat the resident's name and apartment every 4 to 5 minutes until staff physically turn off the pendant.

During an interview, ULP-E stated she was working on another unit and unable to hear all the calls due to the resident she was with was very loud. ULP-E stated she did not respond to the resident's call pendant.

During an interview, ULP-F stated when a call pendant goes on for 15 minutes staff members will the unit or go check to help. ULP-F stated a staff member must manually turned off the call pendant. ULP-F stated he was working the shift and remembered hearing R1's call pendant but could not recall a time and for how long. ULP-F stated he did not respond to the call pendant.

During an interview, ULP-H stated she started her morning shift and noticed a walkie sitting on the nursing counter and she could hear the resident's call pendant alarmed from the walkie. ULP-H stated she went to the resident's room to answer the call pendant, found the resident unresponsive and alerted the licensed practical nurse (LPN). ULP-H stated she turned off the call pendant after she returned with the LPN.

During an interview, the AP stated the resident used a call pendant to call for assistance which alerts staff over their walkies. The AP stated she carried the walkie for the call pendants with her. The AP stated she checked on the resident every 2 hours with the last rounds on the resident at 5 a.m. The AP stated she was sitting down charting when ULP-H went into the resident's room, ULP-H came out of the room and went to get the nurse. The AP stated she heard the call pendants that shift, and her walkie was working. The AP stated she did not hear the resident's call pendant.

In conclusion, 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 by the means of

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.
(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: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The AP is no longer employed at the facility. The facility provided pendant and vulnerable adult re-education with facility unlicensed and licensed staff.

Action taken by the Minnesota Department of Health:

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

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department
Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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 COMMENT: #HL29647001M/#HL29647002C On February 9, 2022, 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 67 residents receiving services under the provider' s Assisted Living with Dementia Care license. The following correction orders are issued for #HL29647001M/#HL29647002C, tag identification 0460 and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 460 SS=I	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to the call pendant of one of one resident (R1) reviewed when R1 activated her call pendant, but no one answered the call pendant for approximately 82 minutes. When a staff member did respond, she found R1 unresponsive. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).	0 460		

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0 460	Continued From page 2 The findings include: R1's medical record was reviewed. R1's medical diagnoses included chronic obstruction pulmonary disease (COPD), depression, and anxiety. R1's service plan, dated October 15, 2021, indicated R1 received assistance with medication administration, toileting, transfer and walking. The same document indicated R1 required oxygen at 2 liters per minute (lpm) Licensee's Device Activity Report dated October 27, 2021, for call pendant indicated R1 activated her call pendant at 5:47 a.m. and continued to go off until manually turned off at 7:09 a.m. The call pendant went off for 82 minutes. R1's progress note dated October 27, 2021, at 8:24 a.m., indicated a staff member told the licensed practical nurse (LPN) R1 was not breathing at approximately 7:00 a.m. The same document indicated the LPN went R1's room and found R1 cool to touch with no vital signs. R1's death record indicated she died October 27, 2021, at 7:17 a.m. the same morning due to chronic respiratory failure and COPD. Licensee's internal investigation initiated October 27, 2021, included a Service Received report which indicated the ULP-C documented providing services at 12:36 a.m. and 3:00 a.m., during the same night shift. However, the same document indicated the services were both documented at 7:04 a.m. and not the actual time of service. The internal investigation included an interview with ULP-C, who said her walkie-talkie-talkie alerting her to the call pendant was working during the shift. The same document indicated ULP-C said she checked on the resident at 6:14 a.m. and she	0 460		

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0 460	Continued From page 3 was doing okay. A review of the facility's security footage dated October 27, 2021, with a view of R1's hallway indicated the ULP-C did not go into this area at 6:14 a.m. During an interview on February 9, 2022, at 3:19 p.m., registered nurse (RN)-B stated the call pendant system sounds across walkie-talkies which staff members are to carry with them. The RN stated the pendant light will continue to repeat the resident's name and apartment every 4 to 5 minutes until staff physically turn off the pendant. During an interview on February 23, 2022, at 2:36 p.m., (LPN)-D stated it is sometimes hard to hear the robot voice from the walkie-talkie. LPN-D stated there is a lot of noise going over the walkie-talkies and she did not remember R1's pendant going off that morning. LPN-D stated if a pendant kept going off you would call to the unit or go to the unit to see to help. During an interview on February 23, 2022, at 4:06 p.m., ULP-E stated she was working on another unit and unable to hear all the calls due to the resident she was with at the time was very loud. ULP-E stated she did not respond to R1's call pendant. During an interview on February 24, 2022, at 3:23 p.m., ULP-H stated she heard the page for R1's room come over the walkie-talkie. ULP-H had come into work early, picked up a walkie-talkie with an earpiece, and started getting a resident up for the day in the same unit R1 was located. ULP-H stated she heard something when she walked out of another resident room and that is when she discovered her walkie-talkie must not	0 460		

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0 460	Continued From page 4 have been working. The page she heard was coming from a walkie-talkie sitting on the nurse cubby counter. ULP-H stated the walker on the counter did not have an earpiece and as soon as she heard the pendant light page, ULP-H went into R1's room. ULP-H found R1 unresponsive and went to get assistance. ULP-H stated she disarmed the pendant in R1's room. During an interview on February 24, 2022, 8:59 p.m., ULP-F stated when a call pendant goes on for 15 minutes staff members will the unit or go check to help. ULP-F stated a staff member must manually turned off the call pendant. ULP-F stated he was working the shift and remembered hearing R1's call pendant but could not recall a time and for how long. ULP-F stated he did not respond to the call pendant. The undated licensee document titled Pendant Response Education, indicated expectations of team members every shift is to use and wear a walkie-talkie. The same document indicated staff members are to charge walkie-talkies. The same document indicated staff members respond immediately to call pendants or communicate with another team member to ensure the response to the pendant occurs. Time Period for Correction: Seven (7) days	0 460		
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	02360		

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02360	Continued From page 5 by: Based on observations, interviews, and document review, the licensee failed to ensure one of one resident reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On April 27, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	