Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL296475643M
Compliance #: HL296477912C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
The Waters of Edina
6300 Colonial Way
Edina, MN 55436
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, 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 fell and sustained a brain bleed. The resident was hospitalized and subsequently died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The residents plan of care was being followed at the time of the fall. After the resident fell, the facility sent the resident to the emergency room where the resident had a computed tomography (CT) scan of the head. There were no negative findings from the CT and the resident was sent back to the facility. Two days later, facility staff were concerned the resident was having increased weakness and the resident was sent to the hospital. Another CT of the resident's head was completed which indicated a large subdural hematoma (bleed) had developed. The resident died at the hospital the next day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included atrial fibrillation, pulmonary hypertension, and chronic heart failure. The resident's services included assistance with dressing, bathing, ambulation, and medication management. The resident's assessment indicated resident was blind in his left eye and required hearing aids. The resident walked independently with a 4-wheeled seated walker.

The resident's progress notes indicated he experienced a fall in his apartment about six weeks after moving to the facility. The resident said he was walking alongside his couch, without his walker, trying to reach his television remote. The resident said he had a "slight fall," but did not hit his head. No injuries were noted. A physical therapy/occupational therapy (PT/OT) referral for deconditioning/fall was requested and received from the resident's provider.

The residents medical record indicated two months later the dining room staff found the resident on the floor. A skin tear was noted on the resident's left side, but no active bleeding was noted. Staff continued to assess and monitor the resident. Two days later, the resident pressed his pendant and staff found him lying on the floor of his apartment, next to the door. The resident said he tried to get a glass of water, lost his balance, and fell. The resident hit his head on the floor and had a painful bump on the back of his head. Staff called 911 to transport the resident to the hospital for further assessment and the resident returned from the hospital later that same day. Two days later staff found the resident in his apartment struggling to get dressed. The resident was short of breath and his lips were slightly colored. The resident said he was feeling a little off, "but no more hospitals." Later that day, the resident's provider said the resident should go to the hospital as he was in acute decompensated heart failure. The resident said he felt exhausted, but he was able to speak clearly. A family member brought the resident to the emergency room. The next day, the resident passed away at the hospital.

Hospital records indicated after the resident fell and hit his head, he was seen in the emergency room, but was not admitted to the hospital. The resident experienced no loss of consciousness but did complain of pain to the back of his head and his left shoulder. An electrocardiogram (EKG) revealed atrial fibrillation (a condition causing irregular and often rapid heartbeat in the upper chambers of the heart), which was a chronic condition for the resident. A chest x-ray revealed marked heart enlargement and pulmonary congestion. A cervical spine x-ray revealed the resident had a C2 fracture. Neurosurgery was consulted, but there was no plan for specific interventions aside from ice and acetaminophen. A head CT scan revealed no intracranial hemorrhage or acute infarct. The resident did not complain of pain except when his hard collar was placed. The resident was given discharge instructions, follow-up recommendations, and returned to the facility.

Two days later, the resident returned to the emergency room for weakness and syncope (fainting). The resident was described as having fainting episodes over the past week after having coughing fits. The resident's primary care provider (PCP) was concerned the resident was suffering from heart failure decompensation and wanted him to return to the hospital. The resident was admitted to the hospital and diagnosed with acute heart failure. The resident's EKG indicated atrial fibrillation, and a chest x-ray revealed pulmonary edema (a life-threatening condition that occurs when fluid builds up in the lungs, making breathing difficult). A CT scan of the resident's head indicated a large subdural hematoma had developed. Clinical impressions indicated acute decompensated heart failure. The resident passed away the next day. Hospital records indicated cause of death to be subdural hematoma, acute respiratory failure, and atrial fibrillation.

When interviewed, a staff member said the resident experienced a few falls since moving to the facility. He had a history of falls prior to moving into the facility but was fairly independent at the facility and walked using a four-wheeled walker. After the first fall at the facility a physical and occupational therapy consult was requested from the resident's provider. Additional interventions were implemented after subsequent falls until the resident was hospitalized.

When interviewed, a family member said the resident had started falling about a year and a half prior to moving into the facility. Prior to moving into the facility, one of the resident's falls resulted in a large hematoma that needed to be surgically removed. The family member believed this was likely due to the resident taking blood thinners to manage his cardiac issues. A month later the resident fell and shattered his hip, requiring a hip replacement. About six months prior to moving into the facility, the resident began to experience coughing fits which triggered fainting, causing the resident to fall. Regarding the resident's final fall at the facility, when he hit his head, the resident was evaluated in the emergency room and then sent home, to the disagreement of the facility, the family member, and the resident's PCP. The resident's PCP intervened and two days later the resident was admitted to the hospital for further assessment. The family member stated the facility was following the residents plan of care and they had no concerns regarding the care the resident received.

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.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed the resident appropriately and obtained a higher level of care for the resident as needed.

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
	29647	A. BUILDING: _____ B. WING _____	C 12/03/2024

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 ******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: #HL296477224C/ #HL296475282M and #HL296477912C/ #HL296475643M On December 3, 2024, 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 132 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL296477224C/#HL296475282M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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

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02360	Continued From page 1 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 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		