

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL308124843M  
**Compliance #:** HL308128258C

**Date Concluded:** February 6, 2024

## **Name, Address, and County of Licensee**

### **Investigated:**

The Waters of Eden Prairie  
431 Center Drive  
Eden Prairie, MN 55344  
Hennepin County

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

### **Evaluator's Name:**

Lisa Coil, 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 facility did not administer scheduled medications as ordered.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. The facility nurse notified hospice complex wound care was not a service provided at the facility. The facility nurse informed the hospice nurse that skilled nursing or hospice nursing would have to complete the wound care as ordered.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted hospice. The investigation included review of the resident record(s), hospice record(s), staff schedules, and related facility forms.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included left leg fracture and osteoporosis. The resident's service plan included assistance with turning and repositioning and medication management. The resident's assessment indicated the resident was not orientated, was receiving hospice services, was no longer getting out of bed, received wound cares to a wound on her butt and to a wound on her spine. The resident was enrolled in hospice.

The facility's Uniform Disclosure of Assisted Living Services and Amenities (a required document to describe the services, supports, and amenities available at the assisted living facility) indicated the facility provided basic wound care but did not provide complex wound care. This was indicated by an "x" in the "available" column next to basic wound care and no "x" in the "available" column next to complex wound care.

The progress notes indicated an order was received for an antibiotic to be crushed and sprinkled on the wound bed once a day. The note included another order which indicated to do wound care to a pressure wound on the spine. The wound care included clean with cleanser, pat dry, apply calcium alginate to wound, cover with Opti foam dressing, hospice to do three times per week, facility to do all other days, and may replace if soiled or rolled. The same note indicated the facility nurse discussed the order with a hospice nurse and explained the facility did not manage complex wound care so it would need to be done by skilled nursing or hospice.

The following day the progress notes indicated the resident was no longer verbally responding to questions, had increased secretions, and was not able to swallow. The notes indicated staff members provided comfort measures to the resident and hospice was notified. The next three days of progress notes indicated the resident remained nonresponsive and staff continued providing comfort cares.

The medication administration record indicated nursing was to change a spine dressing daily and as needed. The record indicated hospice nurse was to complete wound cares on Monday, Wednesday, and Friday. The medication notes section of the record included a note indicating the dressing change was to be done by the hospice nurse and it had been scheduled with hospice. The record had six open days for the wound cares to be completed, none of the days were signed off as completed.

The hospice notes indicated the hospice nurse completed wound care one day (day #1) and the wound was draining a moderate amount of fluid and had a foul odor. The note indicated the hospice nurse notified the provider and an antibiotic and new wound care was ordered.

On day #2 the hospice notes indicated the hospice nurse attempted to change the resident's dressing, but it caused extreme pain, and the resident pushed the nurse's hands away indicating refusal of wound care.

On day #3, the hospice notes indicated the hospice nurse saw the resident, but nothing was documented regarding wound cares.

On day #4, the hospice notes indicated the hospice nurse completed wound care to the pressure sore on the resident's back. Nothing was documented regarding the antibiotic.

On day #5, the hospice notes indicated the hospice nurse completed wound care to the pressure sore on the resident's back. Nothing was documented regarding the antibiotic. A second hospice note on day #5 indicated the antibiotic was ordered and delivered on day #1, the facility misplaced the medication, so it had not been given. The note further indicated the resident was actively dying so the antibiotic was not reordered.

During an interview, the nurse stated complex wound care was completed by skilled nursing or hospice and not done by the facility staff. The nurse stated the day the antibiotic was ordered she notified the hospice nurse the wound care was beyond the scope of practice completed by the nurses at the facility and needed to be completed by skilled nursing or the hospice nurse.

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. The resident was deceased.

**Family/Responsible Party interviewed:** No. Attempts were made but unsuccessful.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

The nurse notified the hospice nurse the facility only completed basic wound care.

**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:  <b>30812</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/19/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE WATERS OF EDEN PRAIRIE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344</b>
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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><b>Initial Comments</b></p> <p>On January 19,2024, the Minnesota Department of Health initiated an investigation of complaint #HL308128258C/#HL308124843M. No correction orders are issued.</p>	0 000		

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