Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319498784M
Compliance #: HL319496524C

Date Concluded: May 16, 2025

Name, Address, and County of Licensee Investigated:
The Waters of Highland Park
678 Snelling Ave. South
St. Paul, MN 55116
Ramsey County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Inconclusive

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 facility staff did not have the resident's pressure relieving air mattress plugged in resulting in pressure sores on the resident's heels.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting accounts provided, there was not a preponderance of evidence to support the resident's air mattress was unplugged and was the direct action that caused the resident's pressure injuries to her heels. When the resident's pressure injuries were identified, they were treated, additional interventions were implemented, and the resident passed away days later at the facility related to her dementia diagnosis.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance. The resident's service plan included assistance with bathing, dressing, grooming, turning, and repositioning. The resident's assessment indicated the

resident had thin fragile skin. The resident was receiving hospice services and had a pressure relieving air mattress.

Complaint documents alleged facility staff left the resident's air mattress unplugged, and the resident was found with pressure ulcers on both heels.

Medical records indicated once the resident's pressure ulcers were identified, the injuries were reported to the hospice and facility nurse. Both nurses assessed the resident's heels the day the injuries were found. A wound dressing was applied to the resident's heels, heel protector boots were applied, and the provider was updated.

During investigative interviews, facility staff reported they could not recall the resident's mattress being unplugged prior to the resident obtaining the heel injury.

During an interview, a hospice staff stated prior to the heel injury the resident's air mattress was observed to be unplugged. A hospice staff member stated after the injuries were assessed the mattress was not unplugged again and was in working order.

During an interview, a hospice nurse stated prior to the incident the resident had interventions in place to prevent skin breakdown including an alternating pressure mattress, turning, repositioning, and incontinent care every four hours. When the concern was reported, the heels were assessed, and the reported pressure ulcers were not open wounds but were identified as pressure injuries. The heels were covered with a dressing, wound care three times a week was implemented and pressure relieving boots were ordered and the resident continued to use the air mattress. The hospice nurse stated the resident had been ill weeks prior to the heel injuries and the resident continued to decline and passed away soon after.

During an interview, the facility nurse stated when the injuries formed there was no documentation that staff ensured the mattress was plugged in; however, staff denied the mattress was unplugged. After the heel injuries were reported the facility followed the recommendations provided by hospice. Even though there was no indication the mattress was unplugged, the facility provided staff education to ensure mattresses are always plugged in when they are in use.

During an interview, a family member stated he was aware of the resident's heel injuries, and he had not seen the air mattress unplugged.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility collaborated with the hospice team and implemented interventions to prevent worsening of the heel injuries.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	31949	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

(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 44G.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: #HL319496524C/#HL319498784M On April 22, 2025, 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 74 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for # #HL319496524C/#HL319498784M , tag identification 1940.	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.	

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01940	Continued From page 1	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure it developed an individual treatment management plan to include all required content for one of one residents (R1)	01940		

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01940	Continued From page 2 who received an ordered treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted September 7, 2021. R1's diagnosis included dementia with behavioral disturbance. R1's hospice records dated November 5, 2024, included use of an alternating pressure mattress. R1's service plan dated December 4, 2024, lacked documentation of R1's prescribed alternating pressure mattress. R1's medical record lacked a Treatment and Therapy Plan including the prescribed alternating pressure mattress and lacked the required content noted below: -documentation of specific resident instructions relating to the treatment or therapy administration: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services: and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of	01940		

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01940	Continued From page 3 treatment or therapy to prevent possible complications or adverse reactions. During an interview on April 30, 2025, at 11:00 a.m., registered nurse (RN)-C stated R1 had an air mattress ordered by hospice. RN-C acknowledged R1's medical record including R1's treatment administration record lacked transcription of the air mattress and stated an air mattress was something she expected staff to know how to use. The licensee's Delegated Nursing Services, Treatments or Therapy Tasks and Supervision policy dated July 26, 2021, indicated a treatment plan with all required content would be developed and implemented for all ordered or prescribed treatments and therapy services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		