Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333598464M
Compliance #: HL333595682C

Date Concluded: January 25, 2024

Name, Address, and County of Licensee Investigated:
Shorewood Landing
6000 Chaska Road
Shorewood, MN 55331
Hennepin County

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

Evaluator's Name: Danyell Eccleston, 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 a resident when the facility failed to escalate signs and symptoms of a urinary tract infection to a medical provider. The resident was transferred to the hospital for treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility contacted the resident's medical provider, requested an order to obtain a urine analysis and culture, and administered an antibiotic according to the medical provider orders. The facility also contacted family regarding the resident's increased confusion and recommended the resident be seen at the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, staff

files, and policy and procedure. Also, the investigator observed the facility and observed staff assisting residents with care.

The resident resided in an assisted living memory care unit. The resident's diagnoses included urostomy (a surgically created hole in the abdomen that allows urine to drain into an attached bag) and dementia. The resident's service plan included assistance with urostomy care, redirection, and medication management. The resident's assessment indicated a nurse would assist with urostomy changes and remind the resident twice weekly to change the bag. The assessment also indicated the resident refused to empty or change the urostomy bag in front of staff, and unlicensed staff would remind the resident to empty the bag every shift.

The resident progress notes indicated six days before the resident went to the hospital the family brought additional urostomy supplies to the facility and a nurse assisted cleaning the area and applying urostomy supplies. The resident was free from fever and denied signs and symptoms of infection.

The resident progress notes indicated five days before the resident went to the hospital the resident showed signs of increased confusion. The resident's vital signs were stable. A facility nurse contacted the medical provider for orders to obtain a urine sample for analysis and culturing. The next day the medical provider ordered a urine analysis and culture and the facility gathered and sent a urine sample to the laboratory for testing. The resident's family was informed.

The residents progress notes the day prior to the resident going to the hospital indicated the resident's urine lab results were still pending and a facility nurse contacted the lab to inquire regarding results. The lab reported results to the nurse and the positive urine bacteria results were faxed to the medical provider who ordered oral antibiotics for the resident.

The resident progress notes indicated on the day the resident went to the hospital the resident took her first antibiotic dose in the morning and became more confused as the day progressed. A facility nurse contacted the resident's family member to report the resident's increased confusion likely related to a urinary tract infection. The resident's family member came to the facility and took the resident to the emergency room. A facility nurse printed needed records for the family member and assisted in getting the resident into the family member's vehicle. Additional progress notes indicated the resident returned to the facility approximately six hours later and a staff member stayed one-on-one with the resident while she was resistant.

Review of emergency room discharge documentation indicated the resident received fluids, antibiotics, and a medication to help the resident calm. At discharge, the resident's temperature, breathing rate, blood pressure, and oxygen level were within normal limits. The resident was prescribed oral antibiotics.

Review of the resident's medication administration record indicated the resident received her first antibiotic dose the morning of the day she went to the hospital. The resident received the same antibiotic and dose for seven days after she returned from the hospital.

Review of video footage from the day of the incident showed the resident was confused and her apartment was in disarray.

During interview, unlicensed personnel stated the day the resident went to the hospital the resident was confused, throwing things on the floor, wandering, declined getting dressed, and was not able to be redirected.

During interview, a nurse stated the resident received an oral antibiotic to treat urinary tract infection the morning she went to the hospital. During the day the resident became increasingly confused; declining to wear pants and eat, wandering into other residents' apartments, taking her clothing out of drawers, and refusing assistance. The nurse believed the resident's delirium was related to her current infection. The nurse contacted the resident's family member and recommended the resident be taken to the hospital.

During interview, a family member of the resident stated she was "horrified" with the resident's level of confusion and apartment condition the day the resident went to the hospital.

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, due to cognitive state.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
	33359	A. BUILDING: _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD LANDING	6000 CHASKA ROAD SHOREWOOD, MN 55331

(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 December 13, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL333595682C#HL333598464M. No correction orders are issued.	0 000		