Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202197144M
Compliance #: HL202193437C

Date Concluded: August 24, 2023

Name, Address, and County of Licensee Investigated:
Lake Minnetonka Shores Assisted Living
4515 Shoreline Drive
Spring Park, MN 55384
Hennepin County

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

Evaluator's Name: Brooke Anderson, 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 was found deceased in a lake near the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was found in the lake deceased, there was no evidence to support that maltreatment occurred. The facility worked closely with the resident's care team and family to assist in the resident's care needs. Facility policies and procedures and the resident plan of care were followed at the time the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the resident's psychotherapist. The investigation included review of the resident's medical records, hospital records, personnel files, camera footage, police reports, and facility policies and procedures. At the time of the onsite visit the

investigator toured facility grounds, including the lake and boat landing area where the resident was found, and observed staff interaction with residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and urine incontinence. The resident's service plan included assistance with medication management, reassurance checks, and shower assistance. The resident was independent with ambulation and able to independently navigate facility grounds. The resident's assessment indicated the resident was cognitively intact with a history of hallucinations, paranoia, and suicide attempts. The resident's assessment included suicide prevention interventions of twice daily reassurance checks, weekly psychotherapist visits, bimonthly psychiatric visits, and monthly intramuscular (IM) psychotropic medication injections. Interventions included on the assessment indicated the resident's significant other would encourage participation in activities, all sharp objects would be removed from the resident's apartment, and monthly care conferences with the resident's family, significant other, case manager, and facility team members.

Hospital records records indicated the resident was seen in the emergency room one week prior to her death with complaints of fatigue, tremors, and intermittent chest pain. The resident was diagnosed with a urinary tract infection and discharged back to the facility four days later.

Upon the resident's return to the facility, staff observed and documented the resident was notably fatigued and did not want to leave her apartment. Due to the onset of weakness and recent hospitalization, a physical therapy evaluation was ordered by the physician.

The day of the scheduled physical therapy appointment, the resident was not in her room when the therapist arrived to begin the 11:00 a.m. appointment. At 10:50 a.m. the therapist reported to facility staff that the resident was not in her room. Staff immediately began a search for the resident.

At 10:58 a.m. the resident's pendant light activated and identified the resident's approximate location as near the independent living garages located on the backside of the facility, near the lake. Staff immediately went to this location and continued their search for the resident. The facility grounds included several feet of lakeshore and multiple boat docks. Due to the proximity of the lake to the facility, staff was aware of the need to complete a thorough search of this area if a resident was reported missing. Search efforts continued but revealed no sign of the resident. Nearby neighborhood search efforts were also unsuccessful. As more staff became aware of the missing resident, search efforts and staff involvement expanded to include approximately 20 staff.

At 11:45 a.m. during continued search efforts, a staff member observed a white shoe floating in the lake. Staff who interacted with the resident that day confirmed the resident was wearing white shoes. Emergency services was contacted and arrived at the facility within minutes with a search and dive team to aide in the search.

At 12:52 p.m. the dive team located the resident deceased in the water.

Following the resident's death, the facility completed an internal investigation. The investigation identified the resident was observed several times the morning of her death. A nurse who encountered the resident at 10:00 a.m. that morning, described the resident as "in a good mood." The resident contacted her psychotherapist for a scheduled appointment via phone at 10:15 a.m. that morning. At 10:45 a.m. the resident spoke with a family member who called to remind the resident of the 11:00 a.m. physical therapy appointment. The family member who spoke with the resident that morning indicated there was no sign of concern during their conversation. Facility camera footage displayed the resident outside of the facility doors closest to the lake at 10:58 a.m. The resident was observed in the entry area, and camera footage displayed the resident briskly walking out of the facility towards the lake. There was no camera footage available of the lake or boat dock area.

The police report was reviewed which indicated police and other emergency services arrived at the facility within three minutes of receiving the report of a missing resident. There was no criminal investigation into the incident and the case was closed.

The resident's death record was reviewed and listed the cause of death as "accidental."

During investigative interviews, multiple staff members stated the resident was independent and struggled with mental health problems. One of the mental health episodes recalled by staff included an incident of self-harm. The resident was described as having a flat affect (no or nearly no emotional expression) at baseline, but multiple staff reported the resident was always polite and nice. Multiple staff members reported that the resident spent most of her time with her significant other, who resided in the independent living facility located on the same facility grounds. Staff members recalled that days prior to the resident's death, the resident returned from the hospital; the resident stayed in her apartment, was notably weak, and seemed "depressed". Staff described the resident as "different" upon her return from the hospital and seemed self- conscious about new tremors she experienced. Multiple staff reported the resident was smiling, happy, and walking at a fast pace the day of her death, which was a noted change in behavior for the resident from the days prior.

During an interview, the resident's psychotherapist described the resident as alert, orientated, and cognitively intact. The psychotherapist explained that over the last couple months, the resident experienced some health issues that changed her affect, however, her participation in visits didn't change despite these health issues. The day of the resident's death, the psychotherapist attempted to hold a scheduled phone meeting with the resident. The resident requested to reschedule the meeting time, stating the timing "wasn't good for her". The psychotherapist was unable to ask to follow up questions because the resident was "rushed". However, the psychotherapist was not concerned with the resident being rushed as this had happened in the past. The psychotherapist stated the entire team involved in the resident's care worked hard to make sure the resident felt supported.

During an interview, the resident's family indicated the facility did a great job in caring for the resident. The family described the staff as "conscientious, caring and involved."

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: Not Applicable
Family/Responsible Party interviewed: No, family declined a formal interview.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility assessed and monitored the resident's condition and mental health status. When the resident was reported missing, facility staff began an immediate search of facility grounds, nearby neighborhoods, and contacted 911. The facility worked closely with the resident's care team and family to assist in the resident's care needs.

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
	20219	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA SHORES	4559 SHORELINE DRIVE SPRING PARK, MN 55384

(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 July 17, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL202193437C/#HL202197144M. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	