Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL252852420M
Compliance #: HL252851561C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:

McKenna Crossing
13810 Shepherd's Path NW
Prior Lake, MN
Scott County

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

Evaluator's Name: Lena Gangestad, 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 he was found outside on the side of the building. The resident was found lying on the ground deceased.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined that neglect was not substantiated. The facility took appropriate steps when the resident was not found in his apartment. When the resident was found outside, he had deceased. The resident's death was unrelated to cares provided or not provided by the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident lived at the facility for several years and experienced overall physical decline over time. The resident's service plan included reassurance checks one to three times a day but remained independent with transfers and ambulating using a four-wheeled walker although quite advanced in age.

One night, the resident attended the bingo activity from 6:30 pm and returned to his apartment around 7:40 pm. At approximately 11 pm, the nurse checked on the resident to ensure he was comfortable and in bed but did not find him in his apartment. The nurse initiated a search for the resident, which included a search of the facility grounds. The resident was found outside lying on the ground at approximately 11:40 pm. and was deceased. The police were notified.

The police report indicated the resident's death did not appear suspicious.

During an interview, the nurse stated it was the end of her shift and she did her round check on all residents to make sure they were in bed and comfortable, but the resident was not in his room, so she initiated a search for him. The resident was found on the ground outside of the facility building. She stated the resident walked independently around the building and was alert and oriented at baseline. That evening he had played bingo, and she did not observe any concerns regarding him or his health.

During an interview, an unlicensed caregiver stated the resident was pretty much independent. He was alert and could make his needs known. The unlicensed caregiver stated she was unaware of concerns regarding him or his health.

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 to interview a family member were unsuccessful.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
They started a search when they did not find the resident in the room. The police were called. The physician and family were notified about the incident.

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
	25285	A. BUILDING: _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENNA CROSSING	13810 SHEPHERDS PATH NW SHAKOPEE, MN 55379

(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 15, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL252852420M/HL252851561C . No correction orders are issued.	0 000		