Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282614722M
Compliance #: HL282616202C

Date Concluded: September 16, 2024

Name, Address, and County of Licensee Investigated:
The Glenn Minnetonka
5300 Woodhill Road
Minnetonka, MN 55345
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 the resident when the facility failed to seek medical care for the resident when the resident showed signs of cognitive decline and was unresponsive.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility contacted emergency services to take the resident to the hospital the day the resident had change from her cognitive baseline. The facility also communicated with the residents provider during the days prior to the resident needing to be sent to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical records, death record, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff members providing care to and interacting with residents.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder, reduced mobility, and mild cognitive impairment. The resident's service plan included assistance with medication management, mobility, repositioning, behavior management, and wellness checks. The resident also had every shift "care alert" service directing staff how to reassure and encourage the resident. The resident's assessment indicated the resident was depressed following the death of her spouse and was previously hospitalized for failure to thrive. The resident needed the assistance of one staff member for mobility, however, the resident desired to stay in bed and declined to leave bed.

Provider notes from seven and six days prior to the time in question indicated the facility contacted the provider because the resident was more weepy than usual and unable to explain what was wrong. The facility also reported the resident had swelling in her extremities with clear lung sounds and no coughing or shortness of breath. The provider indicated the resident had swelling that was due to positioning and limited mobility. The provider indicated the resident had failure to thrive and recommended a hospice evaluation that was dependent on the resident's agreement to be evaluated.

Provider notes from four days before the time in question indicated the resident reported feeling very tired due to not sleeping well. The provider noted the resident had swelling due to limited mobility and home care would be assisting to give extra time and attention and promote movement. On this day, the resident did not want to make any medication changes.

Provider notes from two days before the time in question indicated the resident's provider collaborated with psychiatric team members to change the resident's mental health medication dose.

Facility nurse progress notes three days before the resident was sent to the hospital indicated the resident would not participate in therapies and would close her eyes when asked to perform tasks.

Facility nurse progress notes from the day the resident was sent to the hospital indicated staff reported the resident was "more lethargic and not rousable." The note indicated the resident had a history of not opening her eyes when staff spoke to her, however the nurse assessed the resident and the resident only responded to pain. The nurse contacted emergency services to take the resident to the hospital.

During separate interviews, multiple unlicensed personnel stated the resident was often weepy and sad and that the resident reported she wanted to die so she could be with her deceased spouse. The unlicensed personnel also stated they would try to console the resident and encourage her to move and get out of bed, but the resident would decline.

During interview, a nurse stated the resident preferred to stay in bed and had that preference since admission to the facility. The day the resident was sent to the hospital, a staff member reported the resident was not doing well. The nurse went to check on the resident and a second nurse joined. The resident was not responding, the nurse ran to the nurses' station to contact emergency services while the second nurse stayed with the resident.

During interview, the second nurse stated approximately ten days before the resident was sent to the hospital, the resident was more weepy than usual and was not eating much. The second nurse stated the resident's provider was made aware and continued to monitor the resident. The day the resident went to the hospital, the second nurse was conducting unit rounds when a staff member informed her the resident would not wake up and the second nurse and another nurse went to the resident's room. The resident had a history of refusing to open her eyes at times, however, this morning the resident appeared pale on color and would not wake up when the second nurse rubbed her breastbone to stimulate a response. Emergency services were contacted and took the resident 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, deceased.
Family/Responsible Party interviewed: No, interview declined.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility contacted the resident's provider with medical changes and concerns and sent resident to hospital via emergency services when she became unresponsive.

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
	28261	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GLENN MINNETONKA	5300 WOODHILL ROAD MINNETONKA, MN 55345

(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 August 12, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL282616202C/#HL282614722M. No correction orders are issued.	0 000		