Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL301088442M
Compliance #: HL301085321C

Date Concluded: April 7, 2025

Name, Address, and County of Licensee Investigated:
Water's Edge
800 Agency Trail
Mankato, MN 56001
Blue Earth County

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

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Substantiated, facility responsibility

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 staff routinely did not follow the resident's care plan and used the incorrect type of lift. The resident slipped while staff used the incorrect lift and sustained a leg fracture. The facility also neglected the resident when the resident developed multiple skin wounds which included areas of full thickness skin loss, death of tissue, and inflammation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility allowed staff members to routinely utilize an EZ-Stand (sit-to-stand) lift to transfer the resident to and from a shower chair rather than a Hoyer (full body) lift per the resident's service plan. The resident slid from the EZ-Stand and was later sent the hospital where he was diagnosed with a leg fracture. The facility did not have record of or treatment documentation of multiple skin wounds to the resident's buttocks, heel, ankle, abdomen, and groin, which were found upon admission to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff members interacting with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and frequent falls. The resident's service plan included assistance of two staff members and a Hoyer lift for transfers, twice weekly showers with staff checking skin and reporting any reddened or open areas to nurse or supervisor. The resident's assessment indicated the resident used a wheelchair, had communication difficulties and was not easily understood, and had memory loss. A nurse assessment indicated the resident was at high risk for skin injuries. The resident's last assessment, conducted approximately seven weeks before his leg injury, indicated the resident did not have any wounds, open skin, or history of or current skin issues.

The resident progress notes approximately nine weeks before the time in question indicated an unlicensed staff member noted blood to the resident's brief and no wounds or skin openings were noticed.
The resident progress notes approximately seven weeks before the time in question indicated a foam dressing was on the resident's tailbone.
Approximately four weeks before the time in question the residents progress notes indicated the resident had a small wound to his tailbone and cream would be applied twice a day. No further documentation regarding skin wounds were present in the resident's progress notes

The residents progress notes from the day in question indicated the nurse was informed in the afternoon the resident had bruising and swelling to the left knee and bruising to the inside, upper left arm. The nurse assessed the resident and found his left kneecap displaced to the inside of his left knee. The resident was visually shaking and moaning in pain with touch or movement. Emergency services was contacted.

Hospital records indicated the resident presented with a fractured left leg, swollen and bruised left shoulder, and multiple skin wounds. Hospital records indicated the long bone in the resident's left leg was completely fractured at an angle. The resident had intertrigo dermatitis (an inflammatory skin condition caused by skin rubbing together that becomes worse with heat and moisture) to his groin folds, abdominal folds, and left elbow folds. Stage 3 pressure injury (a skin injury of full-thickness skin loss that extends into the fat and deeper tissue) to his left outer ankle, and unstageable pressure injury (a skin injury when depth cannot yet be determined due to dead tissue covering the injury) to his right outer heel. Moisture associated skin damage to the resident's tailbone area. The resident underwent surgery that included use of nails and screws to mend the leg fracture and the skin wounds were treated with medication, dressings, frequent turning, pressure reducing boots, and a specialized bed to reduce pressure.

During interview, an unlicensed staff stated when she first started working with the resident, the resident used an EZ-Stand lift and then changed to requiring the use of a Hoyer lift. The unlicensed staff stated for shower days staff were not trained to stop using the EZ stand for showers, and it was harder to shower and dress the resident if they used a mechanical lift instead of a EZ lift for showers. The unlicensed staff stated the evening before the resident went to the hospital, she and another staff put the resident in the EZ-Stand lift to transfer to the shower chair when the resident began to slide down and the resident's legs shifted. The unlicensed staff stated an additional staff came to assist and they put the resident to bed and were not aware of any injuries to the resident.

During interview, a second unlicensed staff stated the resident switched to using a Hoyer lift approximately one year before the incident. The second unlicensed staff stated staff would apply cream to the resident when his skin was reddened and denied knowledge of any resident skin wounds during the time in question. The second unlicensed personnel member stated during the evening shift, another staff member came to find him to help with the resident. Upon entering the room, the second staff member saw the resident hanging by the EZ-Stand lift underarm straps with his left leg sticking out to the side of the lift. The second unlicensed personnel member assisted the other staff members to get the resident into bed and then left the room to attend to another area of the facility. The second unlicensed personnel member stated after the incident, he assisted the resident twice during the morning hours, the resident complained his left leg hurt when rolled in bed. The second unlicensed personnel noted marks under the resident's arms and a small bruise to the resident's knee.

During separate interviews, three unlicensed personnel stated it was common practice for staff members to use the EZ-Stand lift when transferring the resident to and from the shower chair despite the resident's service plan indicating a Hoyer lift with assistance of two staff members should be used when transferring the resident.

During interview, a nurse stated she saw a wound to the resident's ankle the day she assessed the resident's leg injury and had not been aware of any wounds the resident had before the day in question. The nurse stated staff could not tell her why they had not made her aware of any wounds to the resident's skin. The nurse stated staff were to transfer the resident using a Hoyer lift and not to use an EZ-Stand lift. The nurse stated staff did not make her aware of any incident regarding the resident or his knee until the afternoon when she assessed his knee. The nurse stated during assessment, the resident's knee was the size of a volleyball and dark purple and blue in color.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes.
Family/Responsible Party interviewed: No, declined interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted follow-up with staff regarding appropriate lift usage.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Blue Earth County Attorney
Mankato City Attorney

Mankato Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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 144G.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: #HL301085321C/#HL301088442M On February 24, 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 31 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL301085321C/#HL301088442M, tag identification 2360, 0800.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	
0 800 SS=G	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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
0 800	Continued From page 1 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of one of one (R2) residents reviewed. Potential for harm occurred when staff continued to use the mechanical standing lift (EZ stand) to transfer R2 when they were aware the lift was not in good working order. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R2's service plan, dated December 30, 2024, indicated the resident required two-person assistance with weight bearing to get in and out of bed, chair, and toilet with an ez-stand. During interview with R2 on February 24, 2025, at 11:31A.M., R2 stated staff members assisted him with transfers with use of an ez-stand lift that was kept in his apartment. R2 stated the handle that moves the legs for stability was not working, but	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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
0 800	Continued From page 2 staff still used the lift to transfer him. During interview with unlicensed personnel (ULP)-A on February 24, 2025, at 11:40 A.M., ULP-A stated the handle on R2's ez-stand lift to splay out legs is stuck and staff are not able to widen the legs for stability. ULP-A stated staff, including himself, continued to use the broken lift to transfer R2. During interview with licensed assisted living director (LALD)-B on February 24, 2025, at 11:48 A.M., LALD-B denied any knowledge of issues with R2's lift and stated staff should have reported the issue. Policy titled Mechanical Lifts, dated March 2024, indicated the licensee will ensure transfers of residents by mechanical lifts are completed to the manufacturer's instructions, training guidelines and policy and procedure. Time period for correction: Seven (7) days.	0 800		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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
02360	Continued From page 3 issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		