Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308122782M
Compliance #: HL308124604C

Date Concluded: December 29, 2022

Name, Address, and County of Licensee Investigated:
The Waters of Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota, 55344
Hennepin County

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

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

Finding: Not Substantiated

Nature of Visit:
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 they failed to adequately address vulnerabilities and supervise a resident (R1) when R1 wandered into another resident's (R2) apartment which resulted to a physical altercation between both residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. R1 had a history of wandering, however R1 and R2 did not have a history of physical aggression with each other or other residents. The facility provided supervision and cares according to the residents individual assessment.

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

records, and policies and procedures. Also, the investigator observed residents and staff providing care in the memory care unit.

R1 and R2 resided in an assisted living memory care unit. R1's service plan included assistance with escorts, bathroom use, dressing, and medications. R1's assessment indicated he had short- and long-term memory impairment, needed reassurance and redirection due to severe disorientation and delusions, and tended to wander safely. R2's service plan included assistance with meal escorts, safety checks, and reminders. R2's assessment indicated she was able to verbalize needs and needed reminders to conduct self-care activities.

Review of incident notes indicated a staff member found R1 in the hallway with R2's cane and was jabbing the cane at individuals in the hallway. The notes indicated R1 went into R2's apartment and R2 stated R1 started choking her and she pushed R2 out of her apartment and used her cane to hit R2.

During an interview, a nurse stated R1 was non-verbal, confused, and tended to need physical activity and often walked the unit. The nurse stated it was very out of character for R1 to have an altercation with another resident and he was usually a calm individual. The nurse stated both residents were assessed after the incident and R2 had a long scratch that went to her lower back. Law enforcement and emergency services were contacted. R1 went to the hospital due to his behavior being out of character and was diagnosed with a urinary tract infection. The following day, R2 went to the hospital for evaluation due to reporting shoulder pain, the hospital assessment did not have further injury findings.

During an interview, the unlicensed staff member stated she found R1 swinging R2's cane in the hallway and R1 attempted to hit her and another individual with the cane. The staff member took the cane away from R1 and he calmed down soon after. The staff member obtained keys to unlock R2's door to check on her. R2 communicated R1 tried to choke her and R2 hit R1 with her cane. The staff member stated R1 walked around the unit frequently and, at times, wandered into other resident rooms and was redirected by staff members. The unlicensed staff member stated R2 tended to keep to herself and not interact with other residents and that there were not any previous altercations involving R1 or R2.

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: R1 not interviewed due to communication and cognitive status, R2 interviewed.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility conducted an internal review of 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
	30812	A. BUILDING: _____ B. WING _____	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(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 Initial comments On November 10, 2022 the Minnesota Department of Health initiated an investigation of complaint #HL308124604C/#HL308122782M. No correction orders are issued.	0 000		