Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314746967M
Compliance #: HL314743333C

Date Concluded: September 14, 2023

Name, Address, and County of Licensee Investigated:
The Waters on Mayowood
827 Mayowood Road Southwest
Rochester, MN 55902
Olmstead County

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

Evaluator's Name: Erin Johnson-Crosby, 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 a resident when the resident fell, pressed her call light, and was not found by staff for ten hours. The resident's call light was not operational at the time of the incident. The resident was hospitalized and diagnosed with a cervical spine fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware of call pendant system malfunctions but failed to ensure proper functionality of the system. The resident fell and, despite activating her call pendant for assistance, remained on the floor for approximately ten hours before being found by staff the next morning. The resident sustained head trauma, multiple rib and cervical fractures, and died approximately one month later. The facility identified the resident's call pendant was not functional at the time of the fall and discovered additional call pendant functionality issues but failed to establish interventions to ensure system repairs were made and the system remained in proper working order.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident, hospital, and facility records. Also, the investigator observed the facility's call light system and tested functionality of resident call lights.

The resident resided in an assisted living facility. The resident's diagnoses included osteoarthritis, macular degeneration, low blood pressure, and high heart rate. The resident's service plan included a call pendant response service package. The resident's assessment indicated the resident was alert, oriented, and at risk for falls. Interventions for fall reduction included having the resident's call light within reach and orienting the resident to use of the call system. The assessment indicated the resident was able to independently activate the call pendant.

The facility's lease agreement included three available options for call pendant response health support services. The first option was complimentary and indicated a staff member would respond and call emergency medical services (EMS) or a family member if assistance was needed. The second option included a cost of $275.00 per month and indicated staff would respond in case of an emergency, or if extra support was required, and required a facility assessment to be completed on the resident. The third option was included with scheduled assisted living services.

The resident's facility lease agreement with included service agreement identified the resident paid an additional monthly fee for call pendant health support services.

Facility documentation identified at approximately 7:30 a.m. one morning, staff heard the resident yelling as they walked past her apartment. Facility staff entered the apartment and found the resident on the bathroom floor with blood around her, head wounds, and scrapes on her arms and legs. The resident reported to staff she fell while on the toilet and had been pressing her call pendant light since 9:00 p.m. last night. Facility staff contacted emergency medical services (EMS) and had the resident sent to the hospital for an evaluation.

Hospital records indicated the resident was diagnosed with head trauma, a C1-C2 cervical (neck) fractures, multiple rib fractures, and significant pain. Hospital records identified surgical intervention of the cervical fractures was discussed but declined by the resident. The resident was placed on comfort cares and died approximately one month later.

The facility's internal investigation of the resident's fall identified the resident's call light was not functional at the time of the fall. The internal investigation documentation indicated the facility tested and found additional call pendants that were not in working order. The non-functional call pendants were replaced, and documentation indicated the facility planned to monitor the functionality of the call pendant system.

During the onsite visit, one month after the resident fell, the investigator tested a resident's call pendant; the pendant did not work. Facility staff were informed of the malfunction and then checked additional resident pendants. According to facility audits, seven additional pendants were identified as not functional.

During an interview, the facility registered nurse (RN) was not aware of why the resident's pendant was not functional at the time of her fall. The RN said the facility was unable to determine what was wrong with the pendant call system and could not solve the problem. The RN stated the call pendant system displayed that some pendants required batteries but after the batteries were replaced, the alert did not clear from the system. The RN recalled that the previous facility nurse had spent time on the phone with the pendant call light company prior to the resident's fall, but the issue was not resolved. The RN stated the root cause of the malfunctioning call light system was not discovered until the call pendant company representative came to the facility the day after the investigator's onsite visit.

During an interview, the Licensed Assisted Living Director (LALD) stated the call pendant system was installed approximately ten months prior to the resident's fall. The LALD stated after the new system was installed, the facility questioned if some pendants were too old and not compatible with the new system. The LALD stated facility staff responsible for setting up the pendants were trained, but acknowledged some pendants were not set-up correctly. The LALD indicated after the resident fell, additional pendants were identified as non-functional and had not been set-up correctly.

During an interview, the resident's family member stated the resident was alert and oriented. The family member said the resident had pressed her call light repeatedly after she fell, and no one came to help. The family member stated the resident paid extra for her call light to be answered and that obviously did not happen. The family member questioned why no staff heard the resident hollering for help throughout the night and why the resident had to lay there for so long.

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 260E.03, Subd. 15
"Neglect" means the commission or omission of any of the acts specified under clauses (1) to (8), other than by accidental means:
(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
After the onsite visit, the facility notified the call light company and checked all resident pendants. The facility is now conducting random audits and have created new steps to ensure call light functionality.

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
Olmstead County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31474	A. BUILDING: _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS ON MAYOWOOD	827 MAYOWOOD ROAD SW ROCHESTER, MN 55902

(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 LICENSING 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: #HL314743333C/#HL314746967M On July 18, 2023, 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 206 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order was issued July 18, 2023, for #HL314743333C/#HL314746967M tag identification 0470. REVISED, tag 470 previously issued in error has been changed to the correct order tag 460.	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 Immediacy was removed as confirmed by investigator's onsite observation on July 19, 2023 and reviewed by evaluation supervisor on July 19, 2023, however noncompliance remained at a scope and severity of F. The following correction order is issued/orders are issued for #HL314743333C/#HL314746967M, tag identification _0460, 0970, 2360,_____.	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=I	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to promptly respond to	0 460		

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0 460	Continued From page 2 requests for assistance following a fall with significant injury for one of one resident (R1) reviewed. The licensee also failed to ensure the call light system was properly maintained to meet the scheduled and unscheduled needs of each resident and respond to requests for assistance of health or safety needs within a reasonable amount of time. This had the ability to affect all 206 residents. This resulted in an immediate correction order on July 18, 2023, at 4:55 p.m. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 The licensee's contract indicated option 2 included: Health Support Response for Unplanned Events indicated staff will respond to calls in case of an emergency or at times where the resident may need extra support. This package was $275.00 per month. R1's service plan dated June 23, 2023, included diagnoses of osteoarthritis and macular degeneration. R1's service plan indicated R1 received the AL [Assisted Living] option 2 package of Health Support Response for Unplanned Events. R1's assessment dated April 27, 2023, indicated R1 was independent with activities of daily living,	0 460		

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0 460	Continued From page 3 was alert and oriented, but was at risk for falls related to poor judgement, dehydration, and low blood pressure. Interventions for fall reduction included having R1's call light within reach, and orient R1 to use of the call system. The assessment indicated R1 was able to utilize the call system and kept the call pendant on at all times. An incident report dated June 11, 2023, at 7:40 a.m., indicated R1 was found lying on the floor in the bathroom, very injured, with head wounds and scrapes on her hands and legs. The contributing factors identified on the report included fall history and age. The report did not include details of the functionality of the call light system. The Minnesota Adult Abuse Reporting Center (MAARC) report dated June 11, 2023, identified at 7:30 a.m., facility staff walked by R1's room and heard yelling. R1 was found in her bathroom with blood around her. Emergency services were called and R1 was admitted to the hospital. R1 reported to facility staff that she fell the evening prior around 9:00 p.m., had been pressing her pendant, and no staff responded. The MAARC report indicated the pendant was not operational at the time of the incident. The resident suffered head trauma, a cervical spine fracture, and a left rib fracture. The MAARC report indicated the licensee immediately began testing all pendants across the community to ensure the pendants were working, replacing any found not operational. The licensee's discharged or deceased resident roster indicated R1 passed away on July 14, 2023. R2	0 460		

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0 460	Continued From page 4 On July 18, 2023, at 3:40 p.m., R2 pressed her call pendant at the investigator's request to check call light response time. R2 said she did not receive any services at the time but paid extra to have the pendant. At 4:02 p.m., R2 stated, "I would be dead by now if I had an emergency. I am paying for this, shouldn't it work?" On July 18, 2023, at 4:24 p.m., unlicensed personnel (ULP)-B walked by R2's room. The investigator asked if R2's call light was activated and ULP-B said no. ULP-B then walked into R2's room and checked R2's pendant. R2's pendant was blinking red, indicating it had been pressed. ULP-B explained to the investigator that she had a list with room numbers on them and stated she was instructed to go around checking pendants. ULP-B worked full time but had never been asked to check pendant functionality and was not aware the call light system was not working. On July 18, 2023, at 4:33 p.m., ULP-B notified the licensed assisted living director (LALD)-A that R2's pendant was not working. LALD-A stated the pendants were tested a month ago and stated, "we were just talking about doing it more often." On July 18, 2023, at 4:55 p.m., LALD-A confirmed the licensee was aware of the malfunctioning pendant system and said they had been through about 50 pendants so far. A policy related to pendant response time was requested, but not provided by the facility. No further information was provided. Immediacy was removed as confirmed by investigator's onsite observation on July 19, 2023 and reviewed by evaluation supervisor on July 19,	0 460		

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0 460	Continued From page 5 2023, however noncompliance remains at a scope and severity of F. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 460		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's provided a blank Resident Lease Agreement dated January 1, 2023, and indicated	0 970		

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0 970	Continued From page 6 the document was the licensee's assisted living contract signed by all residents who lived in the facility. The licensee's Resident Lease Agreement dated January 1, 2023, on page 14, included a section titled 19. Insurance; Personal Property and Loss of Use and read, Management does not maintain insurance covering the content in resident's apartment units or resident property located in the garage. Management may not be responsible for loss or damage to personal property due to theft, damage due to fire, water, tornado or other acts of nature, or other accidents beyond management's control. Management may have the right to require Resident to obtain renters' insurance in such amounts and coverage's as Management may require. If Management gives notice to Resident that insurance is required, Resident shall be required to promptly obtain such insurance and maintain coverage thereafter. The lease also included a section titled Notification Pendant; Disclaimer of Warranty, indicated to the maximum extent permitted by applicable law, the notification pendant is provided "as is" without warranties, conditions, representations or guaranties of any kind, either expressed, implied, statutory or otherwise. The licensee does not warrant that the operation of the notification pendant will be uninterrupted or error free. The residents bear the entire risk as to the performance of the pendant should the service prove defective or incomprehensible. The document advised to not solely rely on the notification pendant for any reason. The next page included a signature page which read, I fully understand and freely sign this Notification Response Pendant Disclaimer of Warranty.	0 970		

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0 970	Continued From page 7 On August 25, 2023, an email from licensed assisted living director (LALD)-A indicated the disclaimer of warranty statement referred to if the resident wore the pendant in the shower since the pendants were not waterproof. LALD-A stated she was aware of the waiver of liability statue and confirmed she was not aware of liability waivers in the lease agreement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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) 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	No plan of correction is required for this tag.	