Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314749805M
Compliance #: HL314747882C

Date Concluded: May 22, 2024

Name, Address, and County of Licensee Investigated:
The Waters on Mayowood
827 Mayowood Rd SW
Rochester, MN 55902
Olmsted County

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

Evaluator's Name: Deb Schillinger, 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 did not respond to the resident's call light leading to the resident to call 911 for his own hospitalization. Additionally, the facility neglected the resident when the facility did not provide catheter cares and/or medication administration.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did call 911 on his own, the facility was following the resident's plan of care and facility policy and procedures were being followed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, staff schedules, and related facility policy

and procedures. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia, benign prostatic hyperplasia (BPH) (enlargement of the prostate gland) and hypertension. The resident's assessment indicated the resident needed the assistance of two facility staff members and a walker to ambulate, had short term memory impairment and occasionally needed redirection. The resident's service plan included assistance with medication management, safety checks, and catheter care.

One morning the resident was admitted to the hospital for a urinary tract infection and deep vein thrombosis (DVT). During the hospitalization, a concern arose that the resident had to call 911 himself because the facility did not answer his call light. Additionally, the resident's blood pressure were found to be high, which raised the concern that the facility was not providing all his medications. The resident had a catheter, and a concern arose it had not been changed in a timely manner.

Facility-provided call light logs for the morning the resident called 911 indicated the resident pressed the call for assistance two times. The call light log showed the first time the call light was pressed the facility staff answered the alert in two minutes, the second time the call light was activated, the alert was responded to in ten minutes.

The resident's Electronic Medication Administration Record (EMAR) indicated the resident's medication for hypertension was given as ordered by the provider. A review of the resident's EMAR indicated no doses for the ordered blood pressure medication were missed.

The Palliative Care Homebound Program consult visit completed by the resident's medical provider after his admission to the facility indicated a urology consult would be arranged by the medical provider for urology testing and monthly catheter changes.

The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the facility was unable to change or manage a Foley catheter, however unlicensed caregivers could empty and change catheter bags.

The resident's medical record indicated the medical provider was notified of resident complaints regarding the catheter on three instances during the month the resident resided in the facility.

During an interview, the nurse stated the resident's provider managed the catheter as the facility would only empty and change the catheter bags.

During an interview, the family member stated the facility did disclose on admission they could only empty and change catheter bags. However, she stated she was told the resident's provider

would come to the facility and change the catheter, but she was not sure if that happened. The family member reported the resident had pressed his pendent at midnight the day the resident went to the hospital and no facility staff responded.

A review of the facility call log did not reveal an alarm was made for assistance from the resident at midnight, the pendent was activated two hours prior to midnight two times and the alarm was answered by facility staff within one minute each time.

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, unable due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Resident hospitalized and discharged to a needed higher level of care.

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
	31474	A. BUILDING: _____ B. WING _____	C 05/01/2024

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 On May 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL314747882C/#HL314749805M. No correction orders are issued.	0 000		