Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL296479082M
Compliance #: HL296477363C

Date Concluded: April 30, 2025

Name, Address, and County of Licensee Investigated:
The Waters of Edina
6300 Colonial Way
Edina, MN 55436
Hennepin County

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

Evaluator's Name:
Maerin Renee, 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 failed to complete the residents daily, "I'm ok" check. Staff found the resident deceased in her apartment after not having been seen in the community for two days.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Staff were directed to complete an "I'm Okay" check daily. The facility did not have a process in place to double-check in case staff missed a resident's checks. This created a domino-effect of missed opportunities in which staff missed the resident's "I'm Okay" check, did not notice newspapers piling up outside her door, nor the fact that the resident missed several meal pick-ups. Staff failed to complete the residents check on Sunday, and staff last saw the resident around dinnertime on Saturday. When staff checked on the resident Monday the resident was found deceased in her apartment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and law enforcement. The investigation included review of the resident record, death record, the facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included coronary artery disease, tachycardia, aortic stenosis, and high blood pressure. The resident's services included nursing assessments and monthly vital signs. The resident's lease indicated the resident received daily "I'm Okay" checks. The resident's assessment indicated the resident was independent with cares and was a full code.

The facility's internal investigation indicated staff had not seen the resident in the community for over two days and was last seen in the community picking up lunch on Saturday. On Sunday, the resident did not respond to her "I'm Okay" check, but the facility concierge did not notify staff to check on her. On Monday, the resident again did not respond to her "I'm Okay" check. The facility concierge notified staff, and they checked on the resident later that afternoon. Two staff members entered the resident's apartment and found the resident deceased, lying on the floor at the foot of her bed. Staff called 911 and emergency personnel confirmed there was no heartbeat.

The police report indicated although the resident was a full code, no resuscitation efforts were performed because the resident showed prolonged signs of death. The resident was lying on her bedroom floor near the right side of the bed, on her right side with her left elbow on top her body. A large gash was noted on the resident's left elbow. The gash appeared to be one or two days old, surrounded by dried blood and bruising. A nightstand near the resident's bed had been moved slightly and items on top were knocked over. There was a spotted blood trail from the nightstand to where the resident was found lying on the floor. The police officer observed lividity in the resident's body as well as rigor in her limbs.

The resident's death record indicated the immediate cause of death was natural causes due to heart failure due to aortic stenosis, atrial tachycardia, and high blood pressure. The manner of death was natural.

When interviewed, a nurse said the facility provided "I'm Okay" checks every 24 hours. Each resident was to press their "I'm Okay" button in the morning. If they did not press that button, the facility concierge would call the resident. If the resident did not answer, the concierge would notify staff to check on the resident. One Sunday the resident did not press her "I'm Okay" button. The concierge attempted to call the resident but did not reach her. The concierge did not notify staff to check on the resident, per protocol, so staff did not see or hear from the resident that day. On Monday, the resident again did not respond to the "I'm Okay" check, but

the concierge did notify staff to check on her. Staff checked on the resident and found her deceased in her apartment.

When interviewed, staff leaders said the weekend concierge was working Saturday and Sunday, and staff found the resident deceased on Monday. Staff leaders said if residents did not check in, the system would populate an email (a push report) to staff leaders and the concierge. The concierge would review the push report and call any residents who had not checked in. By noon, if a resident had not been seen nor responded to the call, the concierge would send a text to the nurse team to check on that resident. Leadership discovered the resident had not received her “I’m Okay” check on Sunday. The weekend concierge said she overlooked it as Sunday was very busy. On Monday the full-time concierge returned and when the resident did not check in, the concierge attempted to call. The resident did not answer, and the concierge notified staff to check on her. Staff then found the resident in her apartment deceased.

When interviewed, a facility concierge said residents were asked to press their “I’m Okay” pendants before 10:00 a.m. every day. After 10:00 a.m., the concierge would get a printout of residents who did not press their “I’m Okay” pendants. The concierge would then call each of those residents to see if they were alright. If the concierge was unable to get a hold of certain residents, the concierge would text the nursing team and someone on that team would check on the residents. The concierge said on Sunday she received a list of residents who had not checked in and called them. She texted the room numbers of residents who had not answered their phones to the nurse team. Although the resident had not answered the concierge’s call, the resident’s room number was not included on the list that was texted to the nurse team. The concierge said she did not know why she did not include the resident’s room number on the list. The concierge was unaware of any backup process or doublecheck in case something like this would happen again. There would not have been any way for her or another staff member to know if a resident had been inadvertently left off the list. The office worker noted that the resident’s newspapers piling up outside her door and the resident not picking up meals could have been clues for other staff members to notice as well.

When interviewed, family members said they were notified of the resident’s passing on a Monday. Whey they arrived at the facility and entered her apartment, it appeared she had taken her Saturday medications, but not her Sunday medications. Staff told family the resident had been seen on Saturday around noon, but no one had seen her on Sunday. One family member said the resident’s newspapers had piled up outside her door even though the resident read her newspaper religiously every day. Family said staff were supposed to check on the resident every day. Apparently on Sunday the resident’s name was circled but never checked off, so staff did not check on the resident until Monday afternoon, when they found her deceased.

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” 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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Staff were re-educated on the “I’m Okay” check process. The housekeeping team was educated on the notification process when newspapers were not taken into a resident’s apartment daily.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(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: #HL296477363C/#HL296479082M On April 11, 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 132 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL296477363C/#HL296479082M, tag identification 2360.	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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 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		