Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314748971M
Compliance #: HL314746602C

Date Concluded: December 20, 2023

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: Julie Serbus, 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 unlicensed personnel discovered resident deceased in his apartment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility documented the resident had a recent decline in health and the resident was scheduled to be admitted to hospice that day.

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's facility record, and recent hospital stay medical provider notes. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living specialty care secured unit. The resident's diagnoses included heart failure, chronic kidney disease, and myocardial infarction (heart attack). The resident's service plan included assistance with bathing, grooming, dressing, bed transfers, and oxygen management. The resident's change in condition assessment completed less than two weeks prior to death indicated the resident was orientated to person, place, and time, and could use his call pendent. This same assessment indicated he did not require safety checks/comfort checks.

The resident's progress notes indicated the resident had been requiring more assistance and was scheduled to meet with hospice the day he passed away. The same documents indicated the resident was recently hospitalized and started on oxygen via nasal cannula related to changes in breathing. The facility updated the resident's medical provider frequently.

During investigative interviews, multiple unlicensed staff members stated resident was able to communicate his needs. The staff members stated the resident had a decline in health but was still able to use his call light and ask for assistance and make his needs known. When unlicensed caregivers entered his room that morning to provide cares, the resident was lying in bed with his call pendant where he always kept it, with bed covers over him, oxygen still in place, but he was unresponsive. The unlicensed caregivers notified the facility nurse to provide an update appropriately.

During an interview, the facility nurse stated the resident was generally independent and active during his daily routine. During the last month prior to his death, he required more assistance related to cardiac (heart) issues. The resident was listed as a do not resuscitate and do not intubate.

During an interview, a family member stated the resident's heart was only working at 20% and was scheduled to be admitted to hospice that day. The family member stated there had been three recent hospital stays and the resident decided he did not want to return to the hospital and chose to enroll in hospice.

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: deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

Action taken by the Minnesota Department of Health:
No further action required.

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 11/14/2023

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 On November 13, 2023, through November 14, 2023,, the Minnesota Department of Health initiated an investigation of complaint #HL314746602C/#HL314748971M. No correction orders are issued.	0 000		