Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329173423M
Compliance #: HL329175452C

Date Concluded: August 1, 2023

Name, Address, and County of Licensee Investigated:
The Waters of White Bear Lake
3820 Hoffman Road
White Bear Lake, MN, 55110
Ramsey County

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

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide supervision. The resident fell and sustained a head laceration.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility staff provided services according to the resident's service plan. The resident had an isolated, unwitnessed fall, and sustained a head laceration. When staff found the resident, they contacted the nurse, and transferred the resident to an emergency room for evaluation.

The investigator conducted interviews with facility staff members including nursing staff. The investigator contacted the resident's family member. The investigation included review of the resident's record, assessments, service delivery records, incident report, and staff schedules. The investigator toured the facility, the resident's memory care unit, and observed staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing, grooming, escorts to meals, and every two-hour safety checks. The resident's assessment indicated the resident stood and walked independently and wandered within the secured unit safely. The resident was disorientated to person, place, and time. The resident was unable to utilize a call pendent due to attempts to consume it. The resident's fall risk assessment indicated the resident was at risk for falls, did not have a history of falls, and fall interventions were in place.

The resident's incident report and facility internal investigation indicated the resident had an unwitnessed fall. Staff found the resident sitting on the dining room floor. Staff contacted the nurse, took vital signs, and the nurse applied pressure to the back of the resident's head to stop the bleeding. The resident also had a left-hand skin tear. The nurse called emergency medical services and transferred the resident to the emergency room for evaluation.

The resident emergency room discharge records indicated the resident had two staples placed to his head laceration and discharged back to the facility the same day.

The residents service delivery records indicated the resident received services according to the service plan, including every two-hour safety checks.

During an interview, a nurse stated the day the resident fell, staff notified her of the fall. Staff found the resident was sitting on dining room floor. The nurse stated the resident was bleeding from the back of the head and she applied pressure to the resident's wound and called emergency medical services. The nurse stated staff working on the unit did not know how the resident fell; the fall was unwitnessed. The nurse stated the resident did not have a history of falls and staff performed safety checks including visualizing the resident to ensure the resident's safety.

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 cognition.
Family/Responsible Party interviewed: No, declined to interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff provided the residents services according to the service plan. Staff notified the nurse of the resident's unwitnessed fall and transferred the resident to the emergency room for evaluation.

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
	32917	A. BUILDING: _____ B. WING _____	C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

(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 July 24, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL329175452C/#HL329173423M. No correction orders are issued.	0 000		