

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203915101M
Compliance #: HL203916788C

Date Concluded: November 8, 2024

Name, Address, and County of Licensee

Investigated:

Cottage Wood Senior Communities
4220 55th St. NW 5
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Lena Gangestad, 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 she fell and hit her head, but the facility delayed having her evaluated by medical staff. She was on anticoagulants and possibly sustained a brain bleed due to the fall.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and hit her head the facility did assess the resident appropriately including updating the medical provider and the resident's family.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian. The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance of one person with all activities of daily living which included hygiene, dressing, toileting, and medications. The service plan also included six to seven times safety checks a day. The resident's assessment indicated the resident require minimal assistance of one person and a front wheel walker for mobility.

One weekend, the resident fell and hit her head, sustaining an abrasion on her left forehead, which was also bruised. The resident was on blood thinner medication. The nurse obtained vital signs and assessed the resident. The family was notified, and a fax was sent to the provider about the incident.

Two days later, a post-fall evaluation was conducted, and safety checks were increased to ensure the resident's safety.

Five days after the fall, the resident fell again, and the facility sent her to the hospital for further evaluation.

The hospital records indicated the resident was admitted due to worsening confusion and recurrent falls. A computed tomography (CT) scan of her head was negative for injury but showed a left frontal subcutaneous hemorrhage, however the injury required no treatment or intervention.

During an interview, an unlicensed caregiver stated the resident was independent when she first moved in a few years ago. More recently, her health started declining as her dementia progressed. The unlicensed caregiver stated the facility checked on the resident at least every two hours, or more often due to her condition. She also said staff members often tried to keep her out in the common areas to make it easier to keep an eye on her. She stated that the resident had a fall mat and a baby monitor in her room to alert staff members when she moved around without asking for help.

During an interview, a nurse stated the resident's condition declined as her disease worsened and fell a couple of times due to confusion and restlessness. The nurse stated staff members checked on the resident frequently and kept her in the common area to make it easier to monitor her. The resident's interventions had included a fall mat alarm in her room, but it was set off too often by her cat, so they had to remove it. Instead, the facility used a baby monitor with the resident when she rested in her room. The facility's practice when a fall occurred was included notifying the family and the medical provider whenever the resident fell and to follow-up with a post-fall assessment.

During an interview, the resident's guardian stated that the facility called and notified her of any falls the resident had. She did not have any concerns about the care the resident received.

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. The resident was resting.

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 taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/15/2024
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NAME OF PROVIDER OR SUPPLIER COTTAGEWOOD SENIOR COMMUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST NW ROCHESTER, MN 55901
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(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	<p>Initial Comments</p> <p>On October 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL203915101M/HL203916788C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____