Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203919649M
Compliance #: HL203917475C

Date Concluded: May 21, 2024

Name, Address, and County of Licensee Investigated:
Cottagewood Senior Communities
4152 55th NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) abused the residents when the AP yanked Resident #1's arm, yanked and forcefully moved Resident #2, and boosted Resident #3 up on the toilet, causing Resident #3's head to hit the wall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information provided, it could not be determined if the alleged incidents did or did not occur. In addition, there was no evidence of bruising or changes observed with any of the residents' mood or behaviors.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of resident records, facility internal investigation documentation, personnel files, staff schedules, and facility policies and procedures. Also, at the time of the onsite visit the investigator observed resident cares.

Resident #1
Resident #1 resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's Disease and dementia with behavioral disturbance. The resident's service plan included assistance with all activities of daily living, behavior management, and safety checks. The resident's assessment indicated the resident was disoriented, had a history of verbal and physical aggression, and was at risk for abuse.

The facility's internal investigation indicated a staff member/alleged perpetrator (AP) pulled on Resident #1's arm, talked to the resident in a mean tone, and pulled Resident #1 down the hallway. The investigation indicated Resident #1 was assessed and no injuries were observed.

Resident #2
Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance and type 2 diabetes. The resident's service plan included assistance with all activities of daily living, behavior management, and safety checks. The resident's assessment indicated the resident was disoriented and was at risk for abuse.

The facility's internal investigation indicated a staff member reported that the AP yanked Resident #2 up by the arms, causing the resident to groan in pain. The investigation indicated Resident #2 was assessed and no injuries were observed.

Resident #3
Resident #3 resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease and osteoarthritis. The resident's service plan included assistance with all activities of daily living including assistance with toileting, behavior management, and safety checks. The resident's assessment indicated the resident was cognitively impaired, had a history of verbal and physical aggression, and was at risk for abuse.

The facility's internal investigation indicated staff members reported that the AP was rough with Resident #3 when assisting with toileting, and Resident #3 became aggressive and slapped the AP. The AP then boosted Resident #3 up so hard off of the toilet that Resident #3's head hit the wall. Resident #3 was not able to stand independently, so the AP sat Resident #3 back down and when they assisted Resident #3 to stand up again, the resident's head hit the wall again. Resident #3 said to the AP, "Ouch, you're hurting me, why do you hate me? You're so mean." Resident #3 was assessed an no injuries were observed.

During investigative interviews, unlicensed staff members stated that the AP was impatient when residents did not move fast enough. The AP yanked or forced residents by grabbing their arms to forcefully guide the residents. One unlicensed staff member stated she witnessed the AP boost Resident #3 up hard, causing Resident #3's head to hit the wall twice while providing toileting assistance.

During an interview, the facility nurse stated that prior to these allegations, the AP was never forceful or rough, was good to the residents, and was reliable staff member. The nurse stated that these allegations caught the facility off guard but stated that the investigation revealed that at some point the AP became more intolerant and gruffer when providing cares. The nurse stated skin audits were completed and no injuries were observed on the resident's involved with the AP's alleged behavior. The nurse stated that after the alleged incidents were reported to her, an internal investigation was conducted immediately. The nurse also stated that facility wide education was completed with all staff and the AP was no longer employed at the facility.

During an interview, the AP denied mistreating, yanking, or using force with residents and that she has never been accused of anything like this before. The AP confirmed Resident #3 hit her head on the wall near the toilet but stated that this occurred when Resident #3 had difficulty standing and during an attempt to pivot Resident #3, the resident's head hit the wall. The AP stated that the resident did not complain of pain at the time the incident occurred.

During interviews with the residents' family members, they stated that they were notified of the allegations involving the AP and reported no concerns.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: R1- deceased, R2 and R3 unable to complete due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and facility wide staff education. The AP is no longer employed by the facility.

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
	20391	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMMUNITIES	4310 55TH STREET NW ROCHESTER, MN 55901

(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 March 6, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL203917475C/#HL203919649M. No correction orders are issued.	0 000		