Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL254608966M
Compliance #: HL254606490C

Date Concluded: May 17, 2024

Name, Address, and County of Licensee Investigated:

Cypress Manor
16770 Wren St. NW
Andover, MN 55304
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 the facility staff failed to complete the resident's oral cares resulting in mucus plugs (mucus that is abnormally thick in consistency and plugs the airway) and a raw reddened throat.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although mucus plugs were suctioned out of the resident's throat, the facility did not have a physician's order, or the means necessary, to complete suctioning on the resident. The facility provided oral care according to the resident's care plan and current medical provider orders.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, death records, hospital records, personnel files, staff schedules, and facility policies and procedures.

Also, at the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included end-stage multiple sclerosis and epileptic spasms. The resident's service plan included assistance with medication administration, wound care, tube feeding, suprapubic catheter, and oral hygiene. The resident's assessment indicated the resident was alert and had very limited vocal abilities. The resident's assessment did not indicate the resident needed oral suctioning.

The resident's hospital record indicated the resident was hospitalized with aspiration pneumonia. The hospital record indicated while a hospital nurse and respiratory therapist were suctioning the resident, a large mucus plug was removed from the back of his throat and throughout his mouth. The resident's throat was red and raw. The hospital record indicated the resident was discharged from the hospital to a higher level of care that could provide suctioning.

The resident's medical record indicated that the resident did receive oral cares every morning, at bedtime, and as-needed, by facility staff. The resident's medical record did not include an order from the medical provider for the resident to be suctioned prior to the hospitalization.

The facility's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) indicated the facility could not provide suctioning for residents.

During an interview, the facility nurse stated that facility staff completed oral cares with mouth swabs, as-ordered, prior to the resident's hospitalization. The facility communicated with the hospital and family that oral suctioning was not a care the facility could provide and after the resident was hospitalized, it was determined the resident required 24-hour nursing care and the facility was unable to provide the cares he needed.

During an interview, a hospital staff member confirmed that the resident's discharge orders from the previous hospitalization did not include suctioning, and that the facility sent the resident to the hospital when a change in condition was noted.

During an interview, a family member stated they had no concerns with the care provided by the facility.

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, resident was deceased at the time of the investigation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed oral cares as ordered, assessed the resident, and sent him to the hospital when needed.

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
	25460	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS MANOR	16770 WREN STREET NW ANDOVER, MN 55304

(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 April 8, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL254606490C/HL254608966M and HL254609311M/HL254607092C. No correction orders are issued.	0 000		