

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL256765285M
Compliance #: HL256767323C

Date Concluded: December 12, 2024

Name, Address, and County of Licensee

Investigated:

Norris Square
6995 80th Street South
Cottage Grove, MN, 55016
Washington 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 alleged perpetrator (AP), an unknown staff member, neglected the resident when the AP failed to provide showering services according to the resident's plan of care. As a result, the resident fell and fractured her hip and knee.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell during a shower, resulting in a fractured left hip and knee, the incident was an accident or a sudden, unforeseen, and unexpected occurrence. At the time of the shower, the AP was following the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the AP. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel file, related facility

policy and procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, memory loss, depression, and anxiety. The resident's service plan included bathroom assistance three times daily, weekly showering with standby assistance, and behavior management including managing the resident's resistive tendencies and verbal aggression. The resident had a history of angry outbursts towards staff, was impulsive and responded to redirection. The resident was incontinent of bowel and bladder, wore incontinent briefs, and was independent with toileting but required encouragement, reminders, and cues to get up to go the bathroom. The resident was disoriented daily with moderately impaired decision making and ambulated without a walker in her room.

Records indicated one evening the resident fell and sustained a fractured knee and hip. The fall was witnessed by staff (AP) in the bathroom during an attempt to give the resident a shower after an incontinent stool episode.

Records indicated the AP responded to the resident's family member's call pendent (a family member who was a resident who lived with the resident in the memory care unit) and found the resident sitting in her recliner full of stool. The AP decided the only way to get the resident fully clean was to provide a shower. The AP turned on the shower to warm up the water and went back to the resident. The AP told the resident "Let's go to the bathroom" to which the resident replied, "I'm not going anywhere." The family member/resident who lived with the resident was also "pleading" with the resident to get up to go to the bathroom. The AP said one of the interventions staff used was to provide the resident compliments that usually motivated the resident to complete the task. The AP told the resident if she got cleaned up, she would "smell good for her hubby." The resident smiled, got up out of her recliner, and walked to the bathroom without assistance. The AP assisted the resident to sit on the shower bench to remove her clothing. The AP said the resident was fine, not upset, until the AP tried to rinse the resident with water. The AP rinsed one arm and suddenly the resident became upset and yelled "I don't want a shower!" and flung herself forward off the shower chair falling on her left knee, and crumpled forward. The AP placed a pillow under her head and called for help. The resident was laying on the floor shouting. Staff attempted to get the residents vital signs the resident resisted and kept yelling. Staff arranged for the resident to be evaluated at a hospital.

Hospital records indicated the resident had surgical repair of a left hip fracture and five days later discharged back to the facility.

The facility investigation concluded the resident sustained a witnessed fall during an attempt to shower the resident after the resident became behavioral and slid off the shower chair, onto the floor, landing on her knee. The AP provided cares and services according to the resident's care plan and there was no evidence to suggest the resident's injury was caused intentionally.

During an interview, the AP stated she wanted to get the resident cleaned up. Initially, the resident did not want to go. The AP provided the resident compliments about wanting to “smell good.” If staff complimented the resident, the resident would laugh, clap her hands, and agree to go. After the compliment, the resident got up and agreed to go. The AP said she had the water running before the resident sat down. As soon as the AP used the running water on the resident, the resident “flung” herself off the shower chair.

During an interview, leadership stated the month leading up to the residents fall, the resident was having behavioral issues with refusal of care, including showers. The facility addressed the concerns with the resident’s provider.

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: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility conducted an internal investigation.

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: 25676	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/13/2024
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NAME OF PROVIDER OR SUPPLIER NORRIS SQUARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6995 80TH STREET SOUTH COTTAGE GROVE, MN 55016
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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 November 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL256767323C/#HL256765285M. No correction orders are issued.</p>	0 000		

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