Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL272866525M
Compliance #: HL272862251C

Date Concluded: December 5, 2023

Name, Address, and County of Licensee Investigated:
Rosewood Senior Living LLC
801 Main Street North
Cambridge, MN 55008
Isanti County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German
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 a resident when facility staff failed to manage the resident's blood sugars and heart failure which resulted in several hospital visits.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility communicated changes in condition to the resident's medical provider and implemented orders per the medical provider's directive.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of personnel records, staffing schedules, resident's medical record, provider notes, hospital records and facility policies. Also, the investigator toured the facility and observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure and diabetes. The resident's service plan included assistance with dressing, bathing, toileting, medication administration and skin care. The resident's assessment indicated she walked with a walker, wore Tubi-grips (tubular bandage that provides firm but comfortable support for swelling) to both legs daily and was incontinent. The resident was alert and oriented to person, place, time, and situation.

While residing at the facility, the resident experienced episodes of high blood glucose readings, bilateral leg swelling and an episode of unresponsiveness. Staff sent the resident to the emergency room to be evaluated on multiple occasions and returned to the facility at her baseline condition.

Nurse's notes indicated the nurse updated the medical provider with blood sugar readings. The provider ordered a short-acting insulin three time daily, and increased the resident's long-acting insulin dosage The notes indicated the nurse updated the provider with weight gains (sign of increased fluid). The provider ordered tubi-grips (a type of compression sock) applied in the morning and removed at night to the resident's legs. The provider also ordered a low sodium diet with a fluid restriction, daily weight checks, and Lasix (a diuretic medication) daily.

During an interview, the nurse stated staff notified her of any changes with the resident. The nurse assessed the resident in person if she was in the building. If she was not, she had staff obtain vital signs. The nurse stated she updated the provider in the communication portal, but if the change was significant, she sent the resident to the emergency room. The nurse stated the provider gave new orders and were implemented. The nurse stated the resident was known to refuse cares and bathing occasionally. The nurse stated any new resident changes or interventions were communicated in person to the staff present and placed in a binder for all staff to review at the start of their shift.

During an interview, a family member stated they had meetings with facility leadership and the Ombudsman to discuss their concerns. The family member stated a facility owner suggested the resident move to a skilled care facility to meet her medical needs. After a hospital stay, the family decided to move the resident to different assisted living facility.

The investigator was unable to reach the resident for interview.

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 to contact.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility communicated to the provider timely and implemented orders accordingly.

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
	27286	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD SENIOR LIVING LLC	801 MAIN STREET NORTH CAMBRIDGE, MN 55008

(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 November 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL272862251C/#HL272866525M. No correction orders are issued.	0 000		