DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307833763M
Compliance #: HL307836297C

Date Concluded: June 16, 2023

Name, Address, and County of Facility Investigated:
Cottage Grove White Pines II
6950 East Point Douglas Road South
Cottage Grove, Minnesota 55016
Washington County

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

Evaluator's Name: James P. Larson
Special Investigator

Finding: Inconclusive

Nature of Visit:
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.

Allegation(s):
The facility neglected the resident when staff failed to monitor and report poor oral intake and a change in condition, resulting in the resident's admission to the hospital's intensive care unit (ICU) for dehydration and required further treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident was hospitalized and required advanced medical treatment, the direct cause of the decline in the resident's condition could not be determined. The status of the resident's condition throughout her stay at the facility was not consistently documented and it could not be established if a lack of monitoring or a delay in reporting a change in condition, led to the resident's decline in status.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also contacted the resident's guardian and made attempts to contact the resident's family. The investigation included review of the resident's medical record, nursing assessments, service plans, care plans, and progress notes. The investigator conducted an onsite visit and observed staff interaction with residents.

The resident resided in an assisted living facility. The resident admitted to the facility following a hospitalization. Hospital notes identified the resident had a history of poor oral intake and included record of less than 25% intake for meals. A facility pre-admission assessment identified a history of food related issues including food fixations, an unwillingness to try new foods when offered, and a history of refusals of medication. The resident's diagnoses included Alzheimer's disease, dementia, and type II diabetes. The resident's service plan included safety checks, assistance with medication administration, blood glucose checks, activities of daily living, housekeeping, and meals.

Three days after admission to the facility, a physician's assistant assessed the resident. Notes from the visit identified the resident's history of poor oral intake but no new orders were prescribed for staff to monitor or record the resident's weight or oral intake. Notes from the visit did not identify concerns with the resident's condition.

Review of the resident's medical record identified the resident began refusing oral medications on day eight of her facility stay. Progress notes identified staff were unable to contact the resident's responsible party to update on the refusals. The resident's medical record identified refusals of blood glucose checks and medications days prior to the observed change in condition. Review of blood glucose readings included no incidence of hypoglycemia (a condition of low blood sugar due to lack of oral intake or eating).

On the morning of the sixteenth day of residency, a nurse was alerted to a change in the resident's condition which included dry chapped lips, refusal to participate in activities of daily living (ADLs), and lethargy. Staff also informed the nurse the resident had refused meals the last four to five days and had limited fluid intake. The nurse assessed the resident for signs of dehydration and other complications related to the resident's diagnoses. The resident's guardian and family were updated on the resident's condition, and the resident was sent to a local hospital for further evaluation.

The resident's medical record included no documentation of the resident's refusals or limited fluid intake on the days leading up to her hospitalization.

Current administrative staff and several nursing staff were new and not employed during the resident's stay at the facility. Staff interviewed could not recall details of the resident's stay.

During an interview with the resident's guardian, they indicated the resident had a history of poor oral intake, refusal of treatments, and wanting to remain in bed prior to admission.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: N/A (Deceased)
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility: The facility alerted the resident’s family when a change in condition was observed. Emergency medical services were contacted, who assumed care and transported the resident to the hospital for further treatment.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health .state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4890 to receive a copy via mail or email.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30783	A. BUILDING: ____ B. WING ____	C 05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	**6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016**

(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 May 19, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307836297C/#HL307833763M. No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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