Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL377852360M
Compliance #: HL377851500C

Date Concluded: May 15, 2024

Name, Address, and County of Licensee Investigated:
Cascade Creek Memory Care
3530 Fairway Ridge Lane SW
Rochester, MN 55902
Olmsted County

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

Evaluator's Name: Deb Schillinger, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 resident #1 and resident #2 when resident #2 threw resident #1 onto the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While the facility moved resident #2 to a new memory care unit to address his behaviors, the facility did not provide communication to caregivers regarding approaches to manage his behaviors or to help him acclimate to the new setting. Resident #1, who lived on the new unit and had a history of loud behavior, was thrown to the ground by resident #2 and required hospitalization. Despite these known concerns, the facility did not put interventions in place to address these risks.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members of residents involved. The investigation included review of the resident record(s), death record, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. The investigator also toured the facility and observed interactions between staff and residents.

Resident #1

Resident #1 lived in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. Resident #1's service plan included assistance with behavior management and redirection, medication management and safety checks. Resident #1's assessment indicated resident #1 walked independently and had nonsensical speech. She had a history of becoming loud and using "babble"-like nonsensical words when frustrated. Resident #1 lived on the first floor of the facility.

Resident #2

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and anxiety. The resident's service plan included assistance with behavior management and redirection, and safety checks. The resident's assessment indicated resident #2 walked independently and behaviors were triggered by loud noises. Resident #2 initially lived on the second floor, but later moved to the first floor of the facility.

Resident #2's risk assessment indicated he did not pose a risk for others.

One day, while living on the second floor, resident #2's progress notes indicated he approached and started yelling at another resident. Initially, one of the caregivers was able to redirect resident #2. However, resident #2 reapproached the resident a five minutes later, took the other resident's wheelchair by the handles, and started lifting the wheelchair up while yelling. A nurse was able to calm R2 by inviting him to a couch, taking deep breaths, and then walking with him.

In the aftermath of this event, resident #2's progress notes indicated the facility planned to move the resident to the first floor because he was "noise triggered" and enjoyed having to room to walk. The same document indicated there would be more room to walk and the atmosphere was "calm" most times of the day on the first floor.

About a week after resident #2 moved to the first floor, the facility completed his level of care assessment which indicated he "very noise triggered" and moved to the first floor for a calmer environment with less continuous activity. The same document indicated resident #2 had declined cognitively and could be redirected with the "correct approach"

A review of the document did not identify specific descriptions or interventions of the "correct approach".

Incident involving Resident #1 and Resident #2
About three weeks after resident #2 moved to the first floor resident #1's progress notes indicated resident #2 grabbed resident #1 by the arms and threw her to the ground. The incident was witnessed by an unlicensed caregiver but was unable to reach either resident in time to intervene.

Resident #1 was transferred to the hospital by emergency medical services and sustained a fractured clavicle. Resident #1 did not return to the facility and died 10 days later.

A review of resident #2's medical record did not identify any updates to his service plan after this event.

During an interview, the nurse stated resident #1 was known to get in other people's faces and babble nonsensical words, but that behavior was only happening one to two times per month.

During the same interview, the nurse stated resident #2 was moved to the same area as resident #1 after increasing episodes of disruptive behavior triggered by loud noises, such as sneezing or coughing. The nurse stated no updates were made to resident #2's service plan during that time, however hourly patient checks were implemented for resident #2 after this incident.

During an interview, an unlicensed caregiver, who witnessed the event involving resident #1 and #2, stated prior to the incident she noticed resident #1 and resident #2 were sitting in the common area watching television. The unlicensed caregiver states she had an uneasy feeling as resident #2 had been aggressive in the past. She saw resident #2 reach out to resident #1 but she could not get over to them to separate them in time. The caregiver described the resident #1 took resident #2's hands and then resident #2 pulled resident #1 by the hands and threw her to the floor striking her head. Then resident #2 turned toward the caregiver and prevented her from providing resident #1 care initially. When asked how the facility provided communication regarding how to manage resident #2's behaviors, the unlicensed caregiver stated she was unable to say.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Vulnerable Adult interviewed: No, Resident #1 is deceased, and resident #2 is cognitively impaired.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Resident #2 moved to a facility to provide a higher level of care. Resident #1 required hospitalization.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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 651-201-4200 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
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL377851500C/HL377852360M On April 10, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 39 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL377851500C/HL377852360M, tag identification 0630 and 2360.	0 000	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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement specific individual abuse prevention plans (IAPP)s and develop individualized interventions to ensure safety and prevent harm to others for four out of four (R1 and R2) residents reviewed after the residents were involved in resident-to-resident and/or resident-to-caregiver altercations. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The findings include: R1 R1's diagnoses included Alzheimer's disease,	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
0 630	Continued From page 2 and heart disease. R1's service plan dated April 18, 2023, indicated R1 required assistance with behavior management and redirection, medication management and hourly safety checks. R1's Fall Risk Assessment, dated October 3, 2023, indicated R1 was ambulatory, had nonsensical speech, and dependent on staff for care. R1 lived on the facility's first floor. R2 R2's diagnoses included Alzheimer's disease and anxiety. R2's service agreement dated January 3, 2023, indicated R2 required assistance with behavior management and redirection, and safety checks for both AM and PM to assure safety. R2's Level of Care evaluation dated February 7, 2024, indicated R2 walked independently. R2's level of care assessment dated January 16, 2024, indicated R2 was "very noise triggered". R2 lived on the facility's second floor but then moved to the facility's first floor. R2's Vulnerability, Safety and risk evaluation dated December 29, 2022, indicated the resident did not pose a safety risk for others. R2's progress note dated January 31, 2024, labeled as a late entry for January 30, 2024, at 7:00 a.m., indicated R2 approached another resident yelling verbal insult. While a caregiver was able to separate the two residents, the same document indicated R2 approached the resident about five minutes later, took the resident's wheelchair by the handles, and started lifting the wheelchair up while yelling. A nurse was able to calm R2 by inviting him to a couch, taking deep breaths, and then walking with him. A review of R2's service plan did not identify the	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
0 630	Continued From page 3 non-pharmacological approaches the nurse used were included or added to his interventions. R2's progress note dated January 30. 2024, indicated the facility planned to move the resident to the first floor because R1 was "noise triggered" and enjoyed having to room to walk. The same document indicated there would be more room to walk and the atmosphere was "calm" most times of the day. R2's level of care assessment dated February 7, 2024, indicated R2 was "very noise triggered" and was moved to the first floor January 31, 2024, to a calmer environment with less continuous activity. The same document indicated R2 "had declined cognitively and could be redirected with the correct approach" A review of the document did not identify specific descriptions or interventions of the "correct approach" R2's progress note dated February 9, 2024, the notes indicated R2 was found eating stool, facility staff unsure if it was another resident or his own. R2's 's progress note dated February 26, 2024, indicated R2 was found by an exit door, naked with a wheelchair lifted as if to throw at an unlicensed caregiver upon the door opening. A review of R2's medical record did not reveal an IAPP was developed, nor an update of R2's service plan with new interventions after incident occurred. Incident involving R1 and R2 R1's progress note entered on February 23, 2024, labeled a late entry for February 22, 2024, indicated R2 had grabbed R1 by her arms, lifted	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
0 630	Continued From page 4 her up and threw her to the ground. The same document indicated R1 sustained a "head strike" during this incident and was transferred by 911 to emergency room. R1 did not return to facility. A review of R1's medical record indicated the facility had not developed an IAPP at the time of this incident. R1's service plan directed facility unlicensed caregivers to redirect resident with snacks and take to a calming area when agitated. A review of R2's medical record indicated the facility had not developed an IAPP at the time of the events described above. The same review did not identify interventions the facility put in place to assist R2 acclimate to first floor where R1 lived. During an interview on February 22, 2024, RN-A stated R2 was triggered by loud noises and was moved to first floor for a quieter environment. R1 resided on the first floor, was known to get into other residents faces and babble, but only 1-2 times per month. RN-A stated R2'sService Plan was not updated after incidents from January 30, 2024, to discharge on March 20, 2024 regarding new behaviors nor was additional training or directions given to unlicensed caregivers. RN-A stated IAPPs were not completed as system did not alert the nurses these assessments needed to be completed. During an interview on February 29, 2024 the licensed assisted living director (LALD) stated an all-staff meeting discussed interventions and approaches training occurred with a certified dementia trainer. However, while documentation of this training	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
0 630	Continued From page 5 was requested, the facility did not provide it. The licensee's Individual Abuse Prevention Plan policy, dated July 2021, indicated the facility would developi ndividualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	