Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56375883M
Compliance #: H56379840C

Date Concluded: January 3, 2024

Name, Address, and County of Licensee Investigated:
Norris Square
6993 80th Street South
Cottage Grove, MN 55016
Washington County

Facility Type: Nursing Home

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP), facility staff, neglected the resident when the AP failed to provide cares according to the resident's care plan resulting in the resident falling out of bed while the AP was changing the residents brief. The resident sustained a femur fracture.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The resident required the assistance of two staff for activities of daily living (ADL's). The AP independently changed the resident's brief. The AP repositioned the resident's bed and failed to lock the bed brakes. When the AP turned away from the resident who was laying on her side in bed, the resident fell out of bed. The momentum of the resident's fall [rolling out] pushed the bed further away from the wall and the resident fell all the way to the floor. The resident was hospitalized with a femur fracture.

The investigator conducted interviews with facility staff and family members. The investigation included review of the resident's medical record, the AP's employee file, facility policies and procedures, and the facility internal investigation of the incident.

The resident resided in a skilled nursing facility with diagnoses including dementia, impaired mobility, obesity, and right below-the-knee amputation. The resident's care plan included assistance with ADLs including dressing, grooming, hygiene, transfers, meals, and medication management. The resident's functional assessment indicated the resident required the assistance of two or more staff to assist with toileting, hygiene, bathing, and bed mobility.

The facility's internal investigation indicated the resident required the assistance of two staff members for dressing, grooming, hygiene, toileting, bathing, bed mobility, repositioning, and transferring with a full mechanical lift. The AP entered the resident's room without a second staff present to change the resident's brief. The AP woke up the resident and the resident became agitated. The AP unlocked the wheel brakes to the resident's bed and moved the bed further from the wall to prepare for the brief change. The AP rolled the resident onto her right side, facing the wall. The AP turned away from the resident to a nightstand to retrieve a fresh brief and draw sheet. As the AP turned back toward the bed, the AP heard a noise and saw the resident rolling toward the wall and off the edge of the bed.

The internal investigation indicated the AP attempted to grab the resident's nightgown to prevent the resident from falling out of bed, however, the resident's weight and momentum pushed the bed away from the wall and the resident fell to the floor. The AP realized she had forgotten to lock the brakes on the bed wheels after repositioning the bed away from the wall. The resident sustained a laceration to her chin and was transported to the hospital. The resident was diagnosed with a femur fracture.

The facility investigation indicated the AP stated she was aware the resident's care plan indicated the resident required two staff to assist the resident with cares. The AP stated she was trying to be helpful because the residents brief change was not difficult. The AP stated she should have called for another staff to assist as soon as the resident became agitated.

The resident's hospital record indicated following the fall the resident was diagnosed with a head injury, a chin laceration requiring stitches, and a femur fracture that required surgical repair. The resident was discharged back to the facility 6 days later.

During interview the AP stated the resident required the assistance of two staff members for transfers, but one staff for other cares. The AP stated while changing the resident's brief, she turned away from the resident, and suddenly the residents bed hit her. The AP turned around and saw the resident falling off the bed. The AP tried to pull the resident to prevent the resident from falling out of bed, but the bed moved preventing the AP from reaching the resident. The AP stated she must not have locked the brakes on the wheels for the bed after she moved the bed prior to changing the resident's brief.

The resident's death record indicated the resident died at the facility 37 days after returning from the hospital. The resident's death certificate indicated injury and trauma contributed to the residents death, and the immediate cause of death was probable complications of femur fracture due to a fall to the floor.

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.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, counseled the AP, and provided staff training regarding care plan requirements.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Cottage Grove City Attorney
Cottage Grove Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33301	A. BUILDING: _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	6993 80TH STREET SOUTH 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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H56375883M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	No plan of correction is required for this tag.	

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2 000	Continued From page 1 #H56375883M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		