Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20391001M
Compliance #: HL20391002C

Date Concluded: September 27, 2022

Name, Address, and County of Licensee Investigated:
Cottagewood Senior Communities
4220 55th Street NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Christine Bluhm, RN
Lena Gangestad, RN
Special Investigators

Finding: Substantiated, individual responsibility

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.

Initial Investigation Allegation:
The alleged perpetrator (AP) neglected a resident when they failed to ensure the resident safely transferred with the mechanical lift from the bed to the chair. The resident fell during the transfer and suffered a broken collar bone and a scalp laceration which required staples.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP did not complete the safety steps with the second

staff person which included checking the loops when the resident was lifted up from the bed and before moving the lift machine. The AP stated that the second staff person operated the lift and lifted resident just above enough to get off the bed and not any higher and when the staff person moved the lift, the left loop on the sling came loose and the resident fell. The second staff person stated the AP had already placed the resident in the sling and started to operate the lift while she first adjusted the Broda chair (a special wheelchair for positioning). The AP nor the second staff person could verify the safety check steps were performed before the fall. The lift was inspected, and lift did not have any defects or breakage.

The investigator conducted interviews with facility staff, including nursing staff, and unlicensed staff. The investigation included a review of facility incident reports, the resident's record and the records of other residents who required mechanical lift transfers. Training files indicated both staff had completed annual mechanical lift training. Also, while on site at the facility, the investigator observed the AP and other unlicensed staff performing mechanical lift transfers during resident care and no concerns were noted.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included services with all personal cares, medications, meals, and housekeeping. The resident's assessment indicated she was cognitively impaired and required assistance with all activities of daily living which included physical mobility assistance from two staff and a sit to stand style or full mechanical lift for all transfers.

Review of the resident's nursing progress note indicated the two staff were transferring the resident from the bed to her Broda wheelchair using the mechanical lift and while the resident was mid-air, one of the sling hooks became loose and the resident slipped out of the sling, landed on the floor, and hit the back of her head.

During interview, the registered nurse (RN) stated both staff were experienced, trained on the use of the mechanical lift, and had used the lift before. The RN stated she expected both staff to complete the preparation and the transfer together. The RN also stated that lift had "C" shaped loop hooks that were different from other lifts used at the facility. The RN stated the mechanical lift was inspected by the manufacturer and did not have any defects and removed from the facility.

During interview and demonstration with the investigator, the AP stated she prepared the resident for transfer while the resident was in bed and waited for the second person. The AP stated she verified the loops were in place. The AP stated that the second staff person moved the lift, the loop near the left shoulder came loose, and the resident slid out of the sling and onto the floor. The AP stated the resident fell because the lift did not have the safety clips.

During an interview with the investigator, the second staff person stated that when she entered the resident's room, the first thing she did was adjust the position of the Broda wheelchair and

the AP already had the resident in the sling. She stated the AP moved the lift and the resident fell.

During interview, a family member stated that the facility told him the resident fell out of the lift because it did not have a safety catch on it. The family member stated he does not want it to happen to someone else's mother. The family member believed the resident would still be alive today if she had not fallen from the lift.

The resident passed away the week of the incident. The resident's death certificate indicated the cause of death was due to complications of Alzheimer's disease, contributed by injury and trauma, and the manner of death is listed as an accident.

A facility skills demonstrated form indicated that two staff are required to complete the entire transfer lift process and that the resident should first be lifted two inches off the bed and the loops are rechecked and secured prior to moving the lift.

In conclusion, the Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment.

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

Action taken by facility:
The facility removed the mechanical lift used in the incident from the facility and inspected for defects by the manufacturer. The facility provided additional training to the AP and other staff that performed mechanical lift procedures.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4890 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
Olmsted County Attorney
Rochester City Attorney
Olmsted County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20391	A. BUILDING: _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMM	4310 55TH STREET NW ROCHESTER, MN 55901

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL20391002C/#HL20391001M #HL20391004C/#HL20391003M On June 28, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 141 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL20391002C/#HL20391001M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On September 27, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	