Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303289085M
Compliance #: HL303286687C

Date Concluded: April 1, 2024

Name, Address, and County of Licensee Investigated:
Westwood Place Inc
209 Jefferson Ave SW
Watertown, MN 55388
Carver County

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

Evaluator's Name: Lena Gangestad
Special Investigator

Finding: Inconclusive

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 the resident by failing to provide thickened liquids as required for his thickened liquid diet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. While it was true there were occasions the facility may have made medical errors regarding the resident's thickened liquids order, there is not sufficient evidence this affected the resident's health or outcome.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident's records, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted secured memory care building. The resident's diagnoses include chronic respiratory failure and dysphagia (swallowing difficulties). The resident's service plan included assistance with all activities daily living, medications, meals, and housekeeping. The resident was enrolled in hospice.

The medical records indicated the resident had an order for thickened liquids due to swallowing difficulty and risk for aspiration (sucking food or liquid into the airway). The same records indicated the resident was found on multiple occasions with thin liquids in his room, which raised a concern for aspiration pneumonia.

About three months prior to this concern the resident had been hospitalized and those records indicated was there for pneumonia, septic shock, and dysphagia with aspiration. While the resident had a diminished appetite, he did drink Pepsi daily as part of his routine. the resident was discharged back after five days later. However, on the day of discharge, he returned to the Emergency Room (ED) later that day due to lethargy. The reason for this hospitalization was failure to thrive, altered mental status, and poor oral intake. During this hospitalization, a video swallow study was done showing silent aspiration with thin liquids, therefore, the resident had been placed on a mechanical soft foods and mildly thick liquid diet regimen. While speech therapy was considered to improve the resident's swallowing, this was not pursued when the resident enrolled in hospice for comfort cares and returned to the facility.

The facility progress notes indicated that caregivers reported the resident was drinking fluids without thickener without issue with no coughing. The same documents indicated that as the resident decline, he was unable to drink thickened liquids on his own and at times the caregivers provided him spoon fed him water. About two months after the resident returned to the facility, Pepsi was found in the resident's room that was not thickened on three or four occasions, which was brought to the facility's attention due to the concern for possible silent aspiration.

In the weeks following this occurrence the hospice records indicated the resident's lung sounds were consistently diminished or absent during several visits throughout the last month of his stay at the facility. Despite this, his oxygen levels remained stable at 94% - 97% while breathing room air.

The resident's death record indicated he died approximately three months after enrolling in hospice. The same document did not list aspiration pneumonia as a cause of death.

During an interview, nurse #1 stated she some staff members were aware of the order for thickened liquid requirement but continued with thin liquids because they felt the resident's passing was imminent and therefore the consistency of the liquid was inconsequential. She stated it was also reported the resident disliked thickened liquids. Nurse #1 stated education on thickened liquids had been provided on multiple occasions, emphasizing that thickened liquids could be added to any beverage but needed to be consumed promptly. Nurse #1 stated she

assessed signs of aspiration during visits, included increased lethargy, frothy sputum, clothing stains, coughing, sputum production, dry heaving, and hiccups. While hospice provided the thickener, the responsibility for staff education rested with the facility.

During an interview, manager #1 stated the resident was admitted to the facility two years ago and was subsequently discharged to a nursing home due to an increasing level of care. Following his last hospital admission, he returned to the facility under hospice care. Upon discharge from the hospital, the resident was placed on a mechanical soft food and thickened liquid diet. The resident preferred and enjoyed drinking soda {Pepsi] but the if he did not drink it immediately the thickener did not maintain its consistency. Manager #1 stated that when nurse #1 raised the concern the facility looked into it and found the thickened soda lost its consistency after about an hour and that had been unknown previously.

During an interview, manager #2 stated once it was discovered the issue with thickened liquids not maintaining its consistency over time, the facility adopted a practice of having the resident drink his thickened beverage, discard what was left and avoid leaving the liquid in his room.

During an interview, unlicensed caregiver #1 stated the resident had been on thickened liquids for a couple of months. The information about the thickened liquid was clearly documented in his record and easy to see.

During an interview, a kitchen staff member stated when the resident returned from the hospital, he started a thickened liquid, which she used to mix into any beverage he desired. She said she did not prepare the mixture until he was ready to drink it, simply following the directions on the package.

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: No. The resident was deceased.

Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility finally adopted a practice of having the resident drank it and discarding the remainder promptly. Everyone was told to prevent leaving the liquid in his room and dispose of it immediately after consumption.

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
	30328	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD PLACE INC	209 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(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 February 21, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL303289085M/HL303286687C. No correction orders are issued.	0 000		