Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304001721M
Compliance #: HL304003320C

Date Concluded: August 2, 2022

Name, Address, and County of Licensee Investigated:
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN, 55721
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN
Special Investigator
Angela Vatalaro, RN
Special Investigator

Finding: Not Substantiated

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(s):
The facility neglected the residents when they failed to have a registered nurse (RN) available to assess both resident 1 and resident 2, who became ill after resident 2 tested positive for Covid-19.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although both residents tested positive for COVID-19, declined and passed away, the RN conducted assessments on resident 1 and resident 2 when changes in condition occurred.

The investigator conducted interviews with facility staff members, including nursing staff, and resident 1 and resident 2's family member. The investigation included review of resident 1's and resident 2's medical records, hospice records, death records, and policies and procedures

related to change in condition and assessments. Also, the investigators observed cares provided to other residents.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included heart failure. Resident 1's service plan included assistance with dressing, bathing, bed mobility, transfers, walking, toileting, and safety checks. Resident 1's assessment indicated resident 1 was alert and confused.

Resident 1's progress notes indicated the RN assessed resident 1 due to falls and exposure to Covid-19. Resident 1 was alert, oriented, had a productive cough, low oxygen saturations levels (measurement of oxygen in bloodstream), and at times removed his oxygen. The RN added fall interventions including implementation of a TABS alarm (a pull string that attaches magnetically to the alarm with a garment clip to the resident) due to resident 1 attempts to self-transfer. The RN also provided staff instruction to monitor vital signs every shift. The next day, resident 1 was weak, had difficulty catching his breath, and resident 1 had a hospice referral. That same day, resident 1 admitted to hospice services. The day after, resident 1's temperature measured 100.4 degrees Fahrenheit. Resident 1 was on oxygen, unable to talk much due to shortness of breath, did not eat lunch, and staff provided fluids as tolerated. A day later, resident 1's temperature measured 99.0 degrees Fahrenheit. Resident 1 drank fluids with staff assistance, and hospice placed the resident on "final moments" with daily scheduled hospice visits. The RN also followed up on resident 1's previous falls. The next day, resident 1's TABS alarm sounded. Resident 1 fell out of bed without injury and staff assisted resident 1 back into bed. The RN received notification of the fall and added one hour safety checks. Resident 1 drank fluids out of a straw and had difficulty talking due to shortness of breath. That same day, the RN assessed resident 1. Resident 1 was alert to self, lethargic, and skin was pale. The same progress note indicated resident 1 had declined since the Covid-19 diagnosis and was on an antiviral (medication to treat Covid-19). Three days later, resident 1 passed away.

Resident 1's death record indicated resident 1's cause of death was natural causes.

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included Alzheimer's. Resident 2's service plan included assistance with dressing, bathing, bed mobility, transfers, walking, and toileting. Resident 2's assessment indicated resident 2 was alert, forgetful, and confused.

Resident 2's progress notes indicated resident 2's temperature measured 101.3 degrees Fahrenheit. Staff notified the RN. The RN provided staff instruction to be notified of any changes included an increase in resident 2's temperature. Later that day, resident 2 no longer had an elevated temperature. Three days later, resident 2 had an elevated temperature, vomited, was tired, and tested positive for Covid-19. That same day, the RN spoke to resident 2's medical provider and requested monoclonal antibodies or an antiviral. The same progress notes indicated discussion of a hospice referral. Resident 2 started an antiviral for Covid-19. The following day, resident 2 was too tired and weak to use the bathroom and had a hard time

catching her breath. Resident 2 received new orders for oxygen and nebulizer treatments (medication used to treat beathing problems). The next day, resident 2 refused lunch and staff encouraged fluids. The day after, the RN conducted an assessment. Resident 2 refused cares during incontinence episodes and continued to take antiviral medication. The RN provided staff instruction to check and change resident 2 every hour. Two days later, resident 2 admitted to hospices services. After three more days, resident 2 passed away.

Resident 2's death record indicated resident 2's cause of death was Covid-19.

During an interview, nurse 1 stated she received notification from facility staff about resident 1 and resident 2's change of condition. Nurse 1 stated she assessed both residents. Nurse 1 stated she received notification regarding resident 1's falls, low oxygen saturation levels, and increased need for staff assistance with activities of daily living. She stated she received notification of resident 2's elevated temperature and positive Covid-19 results. Nurse 1 stated she went to the facility and performed change in condition assessments on both resident 1 and resident 2. Nurse 1 stated resident 1 and resident 2's medical provider and family were also updated with changes. Nurse 1 stated resident 1 and resident 2's medical provider seen both residents during their health decline and hospice services were initiated. Nurse 1 stated both resident 1 and resident 2 passed way.

During an interview, nurse 2 stated the RN was notified of resident 1 and resident 2's changes in condition. Nurse 2 stated the RN assessed both residents.

During an interview, resident 1 and resident 2's family member stated the facility nurses provided updates regarding resident 1 and resident 2's changes in condition. The family member also stated resident 1 and resident 2 received "great care" and had no concerns with care received.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Vulnerable Adult interviewed: No. Resident 1 and resident 2 were deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When resident 1 and resident 2 had a change in condition, facility staff notified the RN. The RN conducted assessments, and both residents' medical provider and family updated.

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
	30400	A. BUILDING: _____ B. WING _____	C 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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 On July 28, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL304003320C/#HL304001721M. No correction orders are issued.	0 000		