

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306972041M

Date Concluded: May 9, 2023

Compliance #: HL306973598C

Name, Address, and County of Facility

Investigated:

Cottage Grove White Pines
6900 East Point Douglas Road South
Cottage Grove, Minnesota
55016
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson
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.

Allegation(s):

The facility neglected the resident when staff failed to implement fall interventions resulting in the resident sustaining multiple falls and fracturing his femur.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained a femur fracture, the resident's service plan, which included fall interventions, was followed at the time the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also conducted an interview with the resident's family. The investigation included review of the resident's medical record, nursing assessments, service plans, care plans, and progress notes. The investigator conducted an onsite visit and observed staff interaction with residents.

The resident resided in an assisted living facility. The resident's diagnoses included presence of bilateral artificial knee joints, bilateral artificial hip joints, and monoplegia (paralysis to one region of the body) of the upper limb. The resident's service plan included safety checks, assistance with medication administration, activities of daily living, housekeeping, and meals.

Upon admission to the facility, nursing staff assessed the resident and identified a history and risk for falls. Fall and safety interventions, including scheduled safety checks, were included on the resident's service plan. In addition, the resident was encouraged to request staff assistance when walking or using his walker.

The night the fall occurred, the resident independently transferred himself from his chair and attempted to walk unassisted to the restroom. During a scheduled safety check, staff found the resident on the floor. The resident was sent to the emergency room for an evaluation and diagnosed with a femur (thigh bone) fracture.

Facility documentation and the resident's medical record indicated the resident's service plan was followed at the time of the fall. The fall occurred in the time between scheduled safety checks.

During an interview with administrative staff, they stated the facility conducted an internal review of the events, and all policies and procedures were followed.

During an interview with a facility nurse, she indicated staff received re-education and additional training following the incident. The resident was admitted to a transitional care unit for rehabilitation services before he returned to the facility.

During an interview with a resident's family member, they indicated the resident had a history of falls prior to admission and they had no concerns with the care provided at the facility.

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.

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: N/A (Deceased)

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: N/A

Action taken by facility: None.

Action taken by the Minnesota Department of Health:

No further action.

cc: The Office of Ombudsman for Long-Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30697	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/20/2023
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NAME OF PROVIDER OR SUPPLIER COTTAGE GROVE WP, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6900 EAST POINT DOUGLAS ROAD SOUTH COTTAGE GROVE, MN 55016
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(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	<p>Initial Comments</p> <p>INITIAL COMMENTS:</p> <p>HL306973598C/ HL306972041M</p> <p>On April 20, 2023, the Minnesota Department of Health initiated an investigation of complaint # HL306973598C. No correction orders are issued.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 000	Continued From page 1	0 000	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	