Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306972980M
Compliance #: HL306972825C

Date Concluded: July 18, 2024

Name, Address, and County of Licensee Investigated:
Cottage Grove WP LLC
6900 E Point Douglas RD S
Cottage Grove, MN 55016-3049
Washington County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Not Substantiated

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 when the resident had an unwitnessed fall and sustained a

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did fall and sustain a fracture, the facility had assessed for falls and had appropriate interventions and services in place.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the legal representative. The investigation included review of the resident health record(s), hospital records, facility internal investigation, facility incident reports, staff schedules, facility falls policy, and progress notes. Also, the investigator observed staff to resident interactions and how resident was always seated in communal areas during the visit.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and dementia. The resident's service plan included assistance with transfers, showering, grooming, and dressing. This same document indicated the resident becomes anxious and does not like to be alone in her apartment.

The resident's assessment prior to her fall indicated the resident used a wheelchair for locomotion and required oxygen. Resident's assessment indicated the resident is only in her room except for when sleeping at night. The same document indicated the resident attended all activities, was on every two-hour safety check and toileting schedule. The resident has a history of falls with no injuries.

The resident's service plan indicated the resident was at risk for falls and had interventions in place to reduce that risk.

An incident report indicated during an overnight every two-hour safety checks the facility found the resident on the floor in her apartment. The caregiver who found her asked another caregiver for assistance, obtained vital signs, ask the resident if she was in any pain, check for injuries, and called the on-call nurse. The on-call nurse instructed the caregiver to check the resident's range of motion and resident's range of motion was within normal limits for the resident. With that completed, the resident was assisted off the floor by two caregivers.

The progress notes indicated the facility the facility continued to observe the resident for pain and swelling. As time passed, the resident was unable to bear weight on her left leg, her knee became swollen and painful to touch. The facility transferred the resident to the hospital later the same morning of the fall.

The hospital record indicated the resident was found to have a pelvic fracture and recommended non-operative management to include weight bearing as tolerated and pain medication.

During an interview, unlicensed caregiver stated she found the resident on the floor in her apartment during a safety check. The caregiver stated the resident had experienced falls in the past related to self-transfers.

During an interview, a nurse stated when she arrived in the morning, she received notification of the resident's fall and information pertaining to fall. The nurse assessed the resident and noted some new swelling and bruising to hand, and resident complained of leg pain. The nurse stated the resident was not moving as she normally would and sent the resident to the emergency department for evaluation. The nurse stated that weeks prior to the incident the resident had been diagnosed with infiltrated lungs and had been on an antibiotic. After the fall, the hospital also diagnosed a urinary tract infection.

During an interview, administration stated the resident's bed was a queen size the resident brought from home, and it was quite high. Prior to this incident the facility had interventions in place to decrease fall risks which included two-hour checks, which the caregivers were following when they found her.

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: No, attempted by resident was not an accurate reporter.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
No action taken.

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
	30697	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WP LLC	6900 EAST POINT DOUGLAS ROAD S 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
0 000	Initial Comments On June 25, 2024,, the Minnesota Department of Health initiated an investigation of complaint HL306972825C/HL306972980M. No correction orders are issued.	0 000		