Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307831341M
Compliance #: HL307838791C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:

Cottage Grove WP II LLC
White Pine, 6950 E Point Douglas Rd S
Cottage Grove, MN 55016
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 facility did not administer medication(s) to the resident as ordered and overdosed the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although it is true the resident required hospitalization and treatment for narcotic (Fentanyl) overdose, the facility followed medical providers orders. When the resident became nonresponsive with shallow breathing, the facility identified this and sought emergency care appropriately.

During the course of the investigation, an allegation of abuse arose but it was inconclusive because there was insufficient evidence to demonstrate abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member, hospice, and

case manager. The investigation included review of the resident's medication administration record, hospice notes, assessments, and progress notes, Also, the investigator completed an onsite visit to observe staff to resident interactions in the memory care units.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with a history of anxiety and hallucinations. The resident's service plan included behavioral Interventions, assistance with transferring and toileting. The resident used a Broda (provides supportive positioning) chair or wheelchair for mobility. The resident was enrolled in hospice. The facility and the hospice made medication changes over time to address issues such as the resident's calling out frequently.

One day the facility found the resident unresponsive with shallow breathing. The facility called 911 for emergency services and the resident was transferred to hospital where he was treated for an accidental overdose of narcotic and placed on a Narcan drip (used to reverse narcotic overdose) overnight.

About seven months prior, the resident's facility medical records indicated the resident's health and behaviors began to decline. During that time, he had an increase in unwitnessed falls, hallucinations, and yelling out. The same records indicated the resident enrolled in hospice due to this overall decline.

To address the resident's increased fall risk due to his decline, the facility completed a risk assessment. The facility and hospice coordinated cares to reduce risk of falls or risk of injury from falls with interventions including use of a hospital bed in the lowest position, a fall mat on the floor next to the bed, positioning resident as far from the edge as possible, Broda chair, Hoyer lift, and placing a pillow on the open side of the bed. The resident's progress notes indicated the facility and hospice also tried interventions such as a talking book player with headphones and other comfort measures to address pain and/or anxiety.

The resident's medication administration record indicated the resident was prescribed a Fentanyl (a narcotic) scheduled to be changed once every three days.

The resident's electronic medication administration record (EMAR) indicated the facility had a system in place in which two caregivers documented application of a new Fentanyl patch and the remove of the old Fentanyl patch every 72 hours. A review of the EMAR indicated two facility caregivers documented both the application of a new patch and the removal of the old patch for the week prior to the resident's hospitalization.

Approximately one week prior to the resident's hospitalization the resident discontinued hospice services. The progress notes indicated the facility reached out the resident's medical provider to see if Fentanyl patches should be continued. The progress notes indicated the medical provider continued the patches.

The progress notes indicated that when the resident was found unresponsive the nurse was contacted who asked the caregiver(s) to check the resident's body for Fentanyl patches. The same note indicated there was one Fentanyl patch present on the resident's body at that time. The facility called 911 and transferred the resident to the hospital. The same note indicated the facility called the daughter and left a voicemail.

The progress notes indicated the facility contacted the hospital the next day to learn the resident had been placed on a Narcan drip (a medication to reverse a narcotic overdose) which had been discontinued early that morning. The same note indicated the hospital reported the resident was awake and alert. The hospital indicated Fentanyl had been discontinued and the resident had a different narcotic pain reliever prescribed.

During an interview, an unlicensed caregiver stated prior to admission to hospice the resident was prescribed medications to treat anxiety and agitation. The caregiver stated hospice added medications including a Fentanyl patch to determine if resident was experiencing pain due his yelling. The caregiver stated the facility trained medication passers changed the narcotic patch every three days and two staff were required to verify removal of old patch and application of a new patch. The caregiver stated the caregivers were required to put their initials on the patch along with dated and document disposal of old patch. The caregiver stated they documented in the EMAR and recorded the location the patch was placed and only four areas of the body were used and rotated each time.

During an interview, a family member stated the family had placed electronic monitoring in the resident's room and observed staff being rough with cares causing pain and verbal yelling. The family member stated while the resident was on hospice the facility administered numerous as needed medications for behaviors, and stated one time two narcotic patches were found on the resident, and once hospice was discontinued the facility continued to administer hospice ordered medications. During the interview, the family member stated she had video recordings which caused her concern for the cares the resident received.

Several brief video clips provided by the family were reviewed. The videos showed instances over the course of approximately three months which included the resident being repositioned in bed, sitting in his Broda chair, and caregivers approaching the resident as he laid on the floor. One video showed resident hanging partially out of bed and caregivers approaching him. However, the videos did not show events that met the definition of abuse.

During an interview, a manager stated the facility became aware of the family member's concern about the cares provided by one unlicensed caregiver but not until after the resident discharged from the facility. The unlicensed caregiver was no longer employed at the facility.

A review of the resident's medical record did not identify changes which could be attributed specifically to the events viewed on videos.

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

“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.

4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
The facility reviewed its policy and procedures regarding administration of Fentanyl via patches.

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
	30783	A. BUILDING: _____ B. WING _____	C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	6950 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 May 22, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL307838791C/#HL307831341M. No correction orders are issued.	0 000		