Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307834445M
Compliance #: HL307837486C

Date Concluded: August 29, 2023

Name, Address, and County of Facility Investigated:
Cottage Grove White Pines II
6950 East Point Douglas Road South
Cottage Grove, Minnesota 55016
Washington County

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

Evaluator's Name: James P. Larson, RN
Special Investigator

Finding: Inconclusive

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 assess and monitor the resident with a change in condition and failed to provide care as directed by the resident's service plan. The resident was hospitalized multiple times within a two-month period for pneumonia, urinary tract infection (UTI), and infected wounds. In addition, staff chemically restrained the resident when medication was administered to "keep her quiet".

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident developed pneumonia and wounds that required hospitalization, it is unable to be determined if the action or inaction of facility staff was the direct cause of the resident's condition or progression of her wounds. Wound care was provided as ordered and the facility made several attempts to arrange for an outside agency to provide additional wound care and treatment. In addition, although the resident's pain management plan wasn't followed the

resident was administered ordered as-needed pain medication. There was not enough evidence to support that staff chemically restrained the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed hospital staff. The investigation included review of the resident's medical record, nursing assessments, service plan, care plan, and progress notes. The investigator also conducted an onsite visit and observed staff's interactions with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia, kidney disease, and history of recurrent pneumonia and urinary tract infections (UTIs). The resident's service plan directed staff to provide assistance with medication administration, safety checks, every two-hour toileting and repositioning, assistance with activities of daily living, laundry, housekeeping services, and meals. The resident's medical record identified the resident had a history of pain and behaviors of frequently yelling or calling out.

Two days after admission to the facility, the resident was sent to the emergency room per the family's request. The resident was diagnosed with dehydration and a urinary tract infection (UTI). The resident was prescribed an antibiotic and returned to the facility that same evening.

Three weeks later, staff reported to the nurse an observed change in the resident's condition. The nurse assessed the resident and noted the resident was congested, had a cough, and was diaphoretic (sweating heavily). The nurse contacted emergency medical services (EMS) and the resident was sent to the emergency room for an evaluation. The resident was admitted to the hospital and diagnosed with pneumonia, UTI, flu, and sepsis (an infection of the blood stream). The resident was hospitalized for ten days and discharged back to the facility.

Staff documented pressure ulcers on the resident's left heel, two days after her re-admission to the facility. The nurse assessed the wounds, then sent a notification and a request for treatment orders to the resident's physician. The next day, the physician assessed the resident and noted an ulcer on the resident's right buttock, verified there was an ulcer on the left heel, and prescribed wound care treatment orders.

Approximately four hours later, EMS was contacted due to a significant change in the resident's condition. The resident was unresponsive, diaphoretic, cold, and crackles were noted in the right lower lobe. The resident was diagnosed with pneumonia and hospitalized for four days.

The resident returned to the facility with a prescription for an antibiotic. The re-admission assessment contained documentation of a right buttock ulcer and coccyx ulcer.

Staff continued to monitor the resident's respiratory status and assess the resident's wounds. The resident's wounds continued to worsen, and staff kept the physician informed of progression of the wounds. Wound care by an outside agency was ordered by the physician.

Approximately two weeks after the resident's most recent re-admission to the facility, the resident was again sent to the emergency room for evaluation due to a change in condition. The resident was admitted for observation and treated for an infected coccyx wound.

The resident did not return to the facility.

Concerns related to medication used as a chemical restraint were also investigated. Current nursing staff members were not employed at the time the alleged incident occurred and had no knowledge of the incident. Review of the resident's Medication Administration Record (MAR) indicated the resident was administered as-needed pain medication, but it is unable to be determined if the medication was used as a chemical restraint. There was no documentation of any negative or adverse effect to the resident due to the use of the medication.

Attempts to contact the resident's family were unsuccessful.

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, deceased.
Family/Responsible Party interviewed: No, attempts to contact were unsuccessful
Alleged Perpetrator interviewed: N/A

Action taken by facility: The facility communicated with the primary care team, outside wound care agency, and family throughout the time the wounds were being treated.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

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 07/14/2023

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 July 14, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307837486C/#HL307834445M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS	

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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.	