Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307836485M
Compliance #: HL307832206C

Date Concluded: August 9, 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 reposition and provide incontinent care in accordance with the resident's service plan. The resident developed bed sores and was hospitalized for wound care. In addition, the facility neglected the resident when staff failed to discontinue a medication in accordance with physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident developed wounds that required skilled nursing care, it is unable to be determined if the action or inaction of facility staff was the direct cause of the resident's wounds. Wound care was provided as ordered, and the facility made attempts for additional evaluations and treatments to be provided for the resident's wounds. In addition, although a medication error occurred, there was no evidence that the resident experienced negative or adverse effects as a result of the error.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also interviewed the resident's family and hospital staff. 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 memory care unit. The resident's diagnoses included chronic obstructive pulmonary disease (COPD), Lewy body dementia, and schizophrenia. The resident's service plan included safety checks, assistance with medication administration and activities of daily living, housekeeping, and meals.

Complaint documents indicated the resident was admitted to the facility after a five-month hospital stay for dementia-related issues and failure to thrive. Upon admission to the facility, facility nursing staff assessed the resident and identified the resident was not able to communicate her needs and had a history of being resistant to care.

The resident's medical record indicated facility staff notified the resident's care team when bed sores were observed on the resident's coccyx and right buttock. Progress notes indicated facility staff made multiple requests for a skilled wound care consult for treatment, but due to insurance issues, this request was denied. Progress notes included documentation that basic wound care was provided by the resident's family and facility staff; however, the resident's wounds worsened. Seven weeks later, the resident was admitted to a local hospital for further evaluation and a need for a higher level of care.

Days later, the resident returned to the facility with physician orders for skilled wound care provided by an outside agency. Skilled wound care treatment was provided as ordered, but the wounds continued to worsen. Progress note documentation indicated the family was notified of the continued progression of the resident's wounds and recommended that the resident be seen in the emergency room. The family declined and requested further consultation by the wound care nurse.

Approximately two weeks later, the resident went to a scheduled appointment at an outpatient wound clinic. The wound clinic transferred the resident to a local hospital emergency room, where she was admitted for advanced wound care treatment.

The resident was discharged from the hospital and admitted again to the facility with orders for skilled wound care provided by an outside agency.

During an interview, a facility nurse stated upon the resident's re-admission from the hospital, the outside home care agency trained the facility nursing staff on the resident's wound care plan of care. Facility staff were trained on the treatments required to be provided in between the days of the scheduled home care agency wound care visits. Facility staff also implemented additional care measures to promote wound healing.

During an interview, a staffing agency nurse stated the resident was still followed for wound care by an outpatient wound clinic and although the wounds remain, they are now healing.

A concern related to a medication error was also reviewed.

A review of the resident record identified that the resident's scheduled Trazadone (an anti-psychotic medication) was changed from daily use to as-needed (PRN) use for insomnia (the inability to fall asleep naturally). Although a physician's order was received, the order was not immediately updated on the resident's medication administration record (MAR). Due to this oversight, staff continued to administer the medication for an additional four days before the resident's family alerted them to the error. When staff became aware of the error, the resident's MAR was updated to reflect the accurate frequency for administration of the medication. The resident's record included no documentation of any adverse effects observed in the resident due to the additional doses of Trazadone administered to the resident.

At the time of the onsite visit, medication was administered as prescribed and resident cares were provided in accordance with the resident's service plan. Documentation review indicated wound care treatment was provided as ordered and the resident's wounds had improved.

During an interview with the resident's family, they indicated the resident had been left in bed or left in a chair on more than one occasion for extended periods of time, ranging from two to eight hours at a time, without being brought to the restroom, and incontinent care was not provided as needed. The family also voiced concern over the resident losing weight during the first six months of her stay at the facility. The family did not have any current concerns about the care being provided by the facility.

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; due to cognitive decline
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility: The facility requested consult for skilled wound care and communicated with the resident's primary care team, outside agency staff, and family regarding the wound care treatments.

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 06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WP II, LLC	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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL307832206C/#HL307836485M On June 28, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL307832206C/#HL307836485M, tag identification 1620 and 1730.	0 000	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 USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure resident 14-day reassessments and on-going monitoring was completed as required for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01620		

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01620	Continued From page 2 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record included R1 had diagnoses of chronic obstructive pulmonary disease (COPD), Lewy body dementia, and schizophrenia. R1 started receiving services from the licensee on December 19, 2022, to assist with medication administration, activities of daily living, housekeeping, and meals. R1's record contained an initial assessment dated December 19, 2022, an assisted living 14-day assessment was not completed on or prior to January 2, 2023. The licensee's 6.01 Assessments, Reviews and Monitoring policy, noted the initial nursing assessment or reassessment would include all of the elements of the uniform assessment tool as required. Resident reassessments and monitoring would be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessments and monitoring would be conducted as needed on changes in needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 3 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review facility staff failed to discontinue medication as prescribed for one of one resident (R1) reviewed for medication errors. R1 continued to receive scheduled doses of trazodone (an antidepressant) for an additional five days after a physician's order for a change in the frequency of administration was received. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included chronic obstructive	01760		

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01760	Continued From page 4 pulmonary disease (COPD), Lewy body dementia, schizophrenia. R1 started receiving services from the licensee on December 19, 2022, to assist with medication administration, activities of daily living, housekeeping, and meals. R1's Medication Administration Record (MAR), dated February 2023, indicated R1 was prescribed trazodone hydrochloride (HCl) 50 milligrams (MG) tablets to be given daily at 8:00 p.m. R1's medical record included a signed physician's order form dated February 8, 2023, that included a change in frequency of administration of the prescribed Trazadone 50 mg to now be scheduled as an as-needed (PRN) medication for insomnia. The document was received by the facility and faxed to the pharmacy on February 8, 2023. R1's February 2023 MAR indicated R1 received the previously scheduled 8:00 p.m. dose of Trazodone HCl 50 MG tablets on February 9, 10, 11, and 12, 2023. The MAR further indicated on February 13, 2023 the Trazodone dose was withheld and not administered to R1. No facility documentation or incident report was available related to this incident and current administrative staff had no knowledge of the alleged incident. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated, "[licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's	01760		

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01760	Continued From page 5 assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		