Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333743183M
Compliance #: HL333745164C

Date Concluded: August 9, 2023

Name, Address, and County of Licensee Investigated:
Birchwood Cottages
1845 Austin Rd.
Owatonna, MN 55060
Steele County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 a resident when the facility failed to reposition the resident every two hours resulting in pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did have pressure ulcers, the facility took appropriate steps to care for the resident's wounds including a repositioning program.

The investigator conducted interviews with facility staff members, including nursing staff, hospice nurse and the resident's family member. The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facilities with dementia care. Her diagnoses included Alzheimer's dementia, diabetes, and pressure ulcers. The service plan indicated she required assistance with repositioning while in bed and when in a wheelchair. The same document indicated she required a pureed diet with thickened liquids and required assistance with meals. The medical record indicated she enrolled in hospice.

On one occasion a concern arose about the status of the resident's pressure ulcers and so the resident was sent to the hospital. The hospital discharge records indicated the resident had blood laboratory work, but the resident returned from the hospital with no new medical orders or wound treatments.

The resident's wound assessment indicated the resident had pressure ulcer wounds on both her left buttock and coccyx since the previous year.

The hospice records indicated the wound dressing were changed 2-3 times a week, and as needed if increased drainage occurred. The same records indicated the wounds might not heal due to the resident's anticipated decline over time. The primary objectives outlined for wound care included managing drainage and odor, comfort, and slowing the progression of her wounds.

During an interview, nurse #1 stated the resident's health was declining so she enrolled in hospice. Nurse #1 confirmed the resident had a wound on her coccyx and was on a repositioning program to prevent her from laying on her back, but she had a tendency to roll back onto her back despite the caregivers' efforts. Nurse #1 stated the family expressed concern about the resident's wound drainage, so the resident went to the emergency room. Later, the resident returned to the facility without any new orders. Nurse #1 stated it was unfortunate, but the resident's wounds were a part of her dying process.

During an interview, nurse #2, who worked part-time at the facility and had previously cared for the resident, confirmed the presence of pressure ulcers on the resident. She stated the facility attempted various interventions, including repositioning, limiting time spent siting on the chair for meals, using different cushions, and trying several types of dressings. Despite these efforts, the condition of the wounds did not improve and continued to worsen. Nurse #2 confirmed staff members diligently turned the resident every two hours, a practice documented and recorded on a paper hung near the resident's bed.

A review of the resident's medical records indicated the facility had documentation of the resident's repositioning program, which showed the facility implemented it consistently.

During an interview, the hospice nurse stated the resident had pressure wounds and given her terminal illness and limited mobility, the focus of her care was on comfort rather than wound healing. The hospice nurse explained the resident's wound care was further complicated by the

resident's inability to feed herself and, despite caregiver assistance, she had weight loss. The hospice nurse stated she observed the caregivers reposition the resident, but she preferred to lay on her back. She stated the caregivers made earnest efforts to prevent further deterioration of her wound.

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, the resident was deceased.
Family/Responsible Party interviewed: No; attempted but not successful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	33374	A. BUILDING: _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

(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 26, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL333743183M/HL333745164C and HL333743943M/HL333746564C. No correction orders are issued.	0 000		