Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339183184M
Compliance #: HL339183259C

Date Concluded: August 25, 2024

Name, Address, and County of Licensee Investigated:
Birchwood Cottages
1630 Lor Ray Drive
North Mankato, MN 56003
Nicollet County

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

Evaluator's Name:
Lisa Coil, RN, BSN, 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 failed to implement intervention(s) to prevent the resident from injury following a number of falls. The resident fell, obtained a fractured skull, and fractured cervical spine. The resident was taken to the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff members provided care according to the resident's plan of care. While the resident did fall and sustain injuries, the facility assessed for falls, and put 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 resident's family member.

The investigation included review of the resident record, death record, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included corticobasal syndrome (a disease that causes areas of the brain to shrink and nerve cells to break down and die, affecting the area of the brain that processes information and brain structures that control movement) and dementia. The resident's service plan included assistance with mobility, transfers, medication management, and behavior management. The resident's assessment indicated the resident was usually understood but confused, forgetful, and anxious.

The resident's plan of care indicated the resident was a high fall risk and was on hourly safety checks. The plan of care indicated the resident rarely used his call light successfully nor remembered it existed. The plan of care further indicated there was a motion alarm at the bedside and bedroom door between the hours of 10:00 p.m. and 7:00 a.m.

A progress note, approximately six weeks prior to his last fall, indicated repeated falls may not be preventable as the resident's physical abilities were declining faster than he was willing to accept. The note indicated the resident's safety judgement was impaired and his anxiety created worsening dyscoordination which increased his fall risk further. The note also indicated staff had communicated to the family member regarding hospice services.

During an interview, a family member stated the resident had a disease which was similar to Parkinson causing his balance to become very unsteady. The family member stated the resident began falling in his apartment, so he moved somewhere he could receive assistance, but things progressed quickly. The family member stated the resident had a shuffled walk, was losing physical control, and falls became more frequent. The family member stated they and the facility had many conversations regarding the resident's falls, but interventions were difficult because the resident was unrealistic about his abilities and wanted to stay in his room during the day.

During an interview, the nurse stated the resident's diagnosis limited his ability to control his right hand and caused severe gait disturbances. The nurse stated the resident had trouble walking through doorways and sitting down in chairs. The nurse stated the resident also had high anxiety which caused jerking movements, adding to the resident's injuries. The nurse stated in addition to completing safety checks and motion sensors, multiple other interventions were attempted to assist in preventing falls. Interventions included different beds, a platform walker, colored tape on the seat of his chair, a square made from colored tape in front of the recliner and toilet, furniture corner guards, and the removal of furniture from his room. The nurse stated interventions were also complicated because the resident wanted to remain independent and refused to use the adaptive equipment suggested. The nurse stated with the rapid progression of the resident's disease, the facility suggested the family think about hospice.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital.

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
	33918	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1630 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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 16, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL339183259C / #HL339183184M. No correction orders are issued.	0 000		