Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL377852790M
Compliance #: HL377854792C

Date Concluded: June 28, 2023

Name, Address, and County of Licensee Investigated:
Cascade Creek Memory Care
3530 Fairway Ridge Ln SW
Rochester, MN 55902
Olmsted County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

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.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to assess a resident after an occupational therapist (OT) reported to the nurse that the resident had foul-smelling urine.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had foul-smelling urine, the nurse responded appropriately to the concern. She obtained an order for a urinalysis and urine culture (UA/UC) and the resident received a 5-day course of antibiotics.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, and facility's policies and procedures. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included history of stroke, hemiplegia (weakness on one side of the body), dementia, and aphasia (inability to or difficulty to speak). The resident's service plan included one-person assistance with transferring and toileting. The same document indicated the resident was incontinent of bowel and bladder.

Based on document review, the OT notified both the nurse and the administrator about her observation the resident had strong-smelling urine. When the nurse inquired of the unlicensed caregivers providing cares, they denied the presence of strong-smelling urine. The concern regarding strong-smelling urine arose again and the nurse contacted the resident's medical provider and obtained an order for a UA/UC.

Two days later, the facility collected the UA/UC and sent it to the laboratory. The resident's progress notes the UA results were faxed to the resident's medical provider the same day although the UC were not available (urine cultures results take longer to obtain).

Approximately five days later, the resident's progress notes indicated the facility had not received any new orders regarding the resident regarding the UA results. The same document indicated the facility emailed the medical provider to inquire. The facility called the laboratory multiple times to check on the results. On this same day, the resident's medical orders indicated the resident was prescribed a 5-day course of antibiotics. The resident's medication administration record indicated she completed the 5-day course of antibiotics.

During the interview, the OT reported that she had noticed the resident had foul-smelling urine during her session with the resident. The OT stated she promptly notified the nurse on three separate occasions regarding this issue. However, the nurse did not take action until a family member became involved.

During the interview, the family member expressed their concerns about the facility's response to the resident's foul-smelling urine as reported by the OT. The family member followed-up with the facility multiple times, but the nurse denied the presence of foul-smelling urine. Eventually, the facility informed her an order was required to obtain a urine sample. When the family member inquired about the results, they were told that the facility was waiting for the culture to come back, but it seems the culture results were never obtained. As a result, the resident was given a 5-day course of antibiotics.

During an interview, the nurses stated she was no longer working at the facility and did not have any recollection or information regarding the specific resident in question.

During the interview, the unlicensed caregiver stated the resident did develop foul-smelling urine at some point last year but could not recall the specific timeframe

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 non-verbal.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The nurse obtained an order for UA/UC test and the resident was administered a 5-day course of antibiotics.

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
	37785	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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 3, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL377854792C/#HL377852790M. No correction orders are issued.	0 000		