*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL383819686M
**Compliance #:** HL383817572C

**Date Concluded:** June 26, 2024

**Name, Address, and County of Licensee Investigated:**
Camilia Rose Cottage
1154 117th Avenue NW
Coon Rapids, MN 55448
Anoka County

**Facility Type:** Supervised Living Facility (SLF)

**Evaluator's Name:** Christine Bluhm, RN
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:**
The facility neglected the resident when the resident fell, sustained an injury, required hospitalization, and the facility did not send a staff member along to accompany the resident. One fall resulted in an injured lip, and the loss of two teeth. The resident was transferred to the hospital for treatment and left unattended in the lobby with gauze to her bleeding lip without staff accompanying the resident because there was only one staff person in the home at that time.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. At the time of the fall one staff member was at the home and could not leave other the residents to accompany the resident to the hospital when transferred by ambulance although the facility did make efforts to contact anther staff member. Although the resident was without staff

supervision for about an hour at the hospital until the guardian arrived, it did not result in harm to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker. The investigation included review of the resident record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident in her living environment at the home.

The resident resided in a supervised living facility (SLF), a small group home type setting. The resident's diagnoses included paranoid schizophrenia and mild cognitive impairment. The resident's service plan included she required oversight with medications, scheduling and accompaniment to medical appointments, transportation setup, meal preparation, and as needed assistance with bathing, grooming, and dressing. The resident attended a structured day program during the week. The resident's assessment indicated she was unsteady, had a history of falls and required frequent reminders to use her walker.

The facility incident report indicated, one night, the resident fell in her room resulting in a bleeding lip. The staff member called the on-call nurse who instructed to call 911. The house manager was also notified and the resident's guardian. The incident report does not indicate what occurred after the staff called 911.

Staffing schedules indicated periods of time at the beginning and end of shifts where there was only one staff member scheduled to be in the building.

The facility policy for Transfers: Hospital, Health Care and Emergency services, indicated that whenever possible, a staff member will accompany the resident and ensure the hospital or care facility has essential information. The same document indicated a staff member should join the person as soon as possible unless the person is determined to be able to independent healthcare decisions or a guardian is with them.

During interviews, the guardian and case manager voiced concerns with staffing and training at the facility. There have been occasions when no one was at the home when the resident returned by bus from the day program. The incident when the fall occurred resulting in a lip injury and loss of two teeth, staff did not accompany the resident and the resident was left in the waiting area unattended for about an hour until the guardian arrived at the hospital. Also, staff did not communicate to family when the resident had increased behavioral changes that included telling stories suggestive of paranoia, not sleeping and weight loss

During an interview, a staff member stated that staff encouraged the resident to use her walker, but the resident sometimes forgot or would not want to use it. He stated he called the guardian after the fall and was informed the guardian would meet the resident at the hospital. He stated that he was the only person in the house at that time and could not go with her. By

the time another staff member was able to go with the resident, the ambulance crew had already left with the resident to the hospital.

During interview, the nurse stated fall preventions were in place for the resident; encouraging the use of her walker, keeping areas free of clutter and ensuring she is wearing footwear. She stated the resident recently had behavioral changes that required hospitalization. The nurse acknowledged staff did not initially communicate these changes to nursing, however, she has since trained staff to watch for and communicate these behaviors right away to her or the manager.

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

**Action taken by facility:**
At one point, a motion alert sensor was added to alert staff of the resident’s movement in her room. The facility provided staff members additional training to recognize the signs of behavioral changes for residents and the need to communicate this to nursing staff right away.

**Action taken by the Minnesota Department of Health:**
No 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 |
|---|---|---|---|
| | 38381 | A. BUILDING: _____ B. WING _____ | C 06/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CAMILIA ROSE COTTAGE | 1154 117TH AVENUE NW COON RAPIDS, MN 55448 |

| (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 |
|---|---|---|---|---|
| 5 000 | Initial Comments<br><br>In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br>On June 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL383817572C/#HL383819686M. No correction orders are issued. | 5 000 | | |