Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203913424M **Date Concluded:** March 14, 2023
Compliance #: HL203915581C

Name, Address, and County of Licensee Investigated:
Cottagewood Senior Communities
4220 55th St NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Julie Serbus, 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(s):
The facility abused the resident when staff members placed the resident in a sensory room, without a nurse's order and indicated to have physical symptoms of shaking, a fixed gaze, and unresponsive.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The unlicensed caregivers consulted with the facility nurse, who provided them direction, when considering placing the resident in the sensory room.

The facility followed protocol for use of the sensory room and had exhausted other choices along with contacting the facility registered nurse and was provided with directions in use of the room.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator interviewed a registered nurse from hospice and the guardian. The investigation included review of the resident's facility record and hospice orders. The investigation included an onsite tour of the facility, the sensory room with photos obtained, and observed staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, panic disorder, and pseudobulbar affect (inappropriate involuntary and uncontrollable crying). In addition to medications, the resident's service plan indicated the resident required frequent redirection and reassurance due to episodes of anxiety, which at times elevated quickly. The resident's care plan indicated other interventions included quiet music, a warm blanket, and essential oil hand massage. The same documents indicated the resident could use the sensory room (a therapeutic space with the intent to provide gentle stimulation of the senses in a controlled way). The resident was also under hospice cares. The resident's nurse assessment indicated the resident had frequent episodes of crying and anxiety. The resident's progress notes indicated the resident had bouts of gazing off and laying down on the floor in his room.

One afternoon the resident's progress notes indicated the resident had increased restlessness and anxiety. Due to the resident's anxiety, he continuously tried to stand up without assistance, which was a concern for a fall so the unlicensed caregivers called the facility registered nurse to discuss use of the sensory room as an intervention to help calm the resident.

The resident's medical record indicated the facility contacted the resident's guardian who gave permission for use of the facility's sensory room.

Later that afternoon, the resident's hospice records indicated hospice wrote a nurse's order to notify both the facility nurse and the hospice nurse prior to utilizing the sensory room.

However, the resident's progress indicated the sensory room was used again the next day for the resident, but hospice had not been consulted.

The resident's progress notes indicated the resident discharged the next day to a hospice setting.

The resident's progress notes indicated there was a discussion between the hospice provider and the facility regarding the use of the sensory room. The same document indicated the facility did follow its internal process regarding the consulting with the facility nurse prior to using the sensory room as a non-pharmacological intervention. The same note indicated the sensory room included mats on the floor and calming lighting. The same note a miscommunication between the facility and hospice may have occurred.

During an interview, the facility registered nurse stated hospice was involved in the resident's care and a hospice nurse visited him one to two times a week. Additionally, hospice provided an aide one to two times a week. She stated hospice provided medications aimed at promoting comfort such as Ativan (an anti-anxiety) and Haldol (an antipsychotic).

During an interview, resident's guardian stated his diagnosis of dementia and pseudobulbar affect caused the resident to where he had uncontrollable bouts of crying, anxiety, restlessness, and anger. The guardian stated overstimulation or noise, or activities can set the resident off. The facility contacted her because neither the medications nor the other interventions were helping console the resident and so they asked for verbal authorization to try the sensory room. The guardian stated the facility had the resident's best interest in mind and wanted to keep him safe.

During an interview, hospice case manager registered nurse stated a hospice nurse was at the facility and found the resident lying on a padded floor in the sensory room. The hospice nurse reported she spoke with facility staff and together they removed resident from the sensory room and attempted to provide care, medication changes, and one on one in order to attempt to calm the resident. The hospice nurse was at the facility most of the afternoon that day and into the evening before the resident calmed down after medication changes and fell asleep. The hospice nurse wrote an order prior to leaving the facility day for staff to contact hospice prior to placing the resident in the sensory room as hospice may need to reassess. The hospice case manager registered nurse stated the following morning the facility called and spoke with the on-call hospice registered nurse and was instructed facility staff to administer an as needed medication listed on the medication administration record and to call hospice back if the medication was not effective. The hospice aide was scheduled that morning to see the resident at the facility and entered the facility within an hour of the medication being given and found the resident in the sensory room at that time. The hospice case manager registered nurse arrived at facility to assess and stated the resident was not responding the nurse, had a fixed gaze and was trembling. Facility staff and the hospice case manager registered nurse removed the resident from the sensory room and throughout the day the resident was one to one related to uncontrolled restlessness and anxiety. Hospice received several medication changes throughout the day and decided a to transfer the resident to the hospice house for symptom control.

The facility's policy reading use of the sensory room indicated the sensory room is only to be used by one resident at a time, a camera is used is monitor the room along with physical checks.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: no, resident is deceased
Family/Responsible Party interviewed: Yes, guardian
Alleged Perpetrator interviewed: Not applicable

Action taken by facility:
The facility followed the service plan and medication administration record to calm the resident and keep him safe. A higher level of care, determined by hospice was needed.

Action taken by the Minnesota Department of Health:
No further action 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
	20391	A. BUILDING: _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMM	4310 55TH STREET NW ROCHESTER, MN 55901

(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 December 28, 2022, the Minnesota Department of Health initiated an investigation of complaints #HL203914143M/HL203917020C and #HL203913424M/HL203915581C. No correction orders are issued.	0 000		