Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203914143M **Date Concluded:** March 14, 2023
Compliance #: HL203917020C

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 neglected the resident when the facility failed to provide assistance with eating, provide supplemental oxygen, and administer the residents' medications as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility documented providing assistance with meals along with the resident's overall decline over time. The facility provided timely updates to the resident's nurse practitioner and medical providers and implemented changes in her medications or supplemental oxygen.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the resident's family members and the medical provider. The investigation included review of the resident's facility record and medical provider notes. Also, the investigator toured the facility and observed staff to resident interactions.

The resident lived in an assisted living memory care unit. The resident's diagnoses included dementia, agitation, aortic valve stenosis (reduced or blocked blood flow from the heart to the rest of the body), and congestive heart failure (when the heart does not pump blood sufficiently causing fluid backup). The resident's service plan indicated the resident required medication administration, one-person physical assistance with feeding, frequent redirection/reassurance, assistance with physical mobility of resident's wheelchair, and two-person physical assistance with transfers.

The resident's medical record indicated the resident had been in the hospital for most of the month prior to admission.

On the day the resident admitted to the facility, the resident's progress note indicated the hospital provided the facility a verbal update stating the resident required staff to feed her. The same document indicated the resident required assist of one to two people using a gait belt and a walker.

During the first week after admission the resident's progress notes indicated the facility monitored the resident's oxygen level twice a day and obtained a weekly weight. The same document indicated the resident had a diuretic (a water pill) as prescribed although the family expressed concern it may need to be increased and also inquired about supplemental oxygen for shortness of breath.

During the second week after admission, the resident's progress notes indicated the facility increased the frequency of weight checks to daily and obtained parameters for reporting changes in weight to the resident's medical provider. The same documents indicated the nurse assessed the resident's lung sounds and found them clear with no signs of respiratory distress. The resident's progress notes indicated the facility checked the resident's oxygen saturation levels multiple times and found it to be greater than 90%, which was consistent with the goals outlined by the resident's oxygen orders. One progress note indicated there were times both family and facility staff members noticed the resident appeared to have some shortness of breath (SOB), which may have been correlated with times of anxiety or agitation.

During the third week after admission, the resident's progress notes indicated the facility direct care givers found the resident's oxygen level was 83% on room air with shortness of breath. The same document indicated the facility obtained an order for oxygen and nebulizer treatments (medicine to improve breathing). The order directed oxygen use of 0-6 liters to keep the resident's oxygen levels above 90%.

Over the next several weeks, the resident's progress notes indicated the facility provided multiple updates to the resident's nurse practitioner, which included episodes of shortness of breath, possible infections, and symptoms related to congestive heart failure (a chronic condition). The orders the facility obtained and carried out included multiple portable chest

X-rays, medication adjustments, and visits to the emergency department. The resident's medical record indicated she was placed on multiple course of antibiotics during this time.

During the fifth week after admission, the resident's progress notes indicated the facility obtained a hospice referral and the hospice evaluation found the resident qualified for hospice services. However, the same documents indicated the family opted to hold off on hospice while addressing the resident's congestive heart failure.

During the sixth week after admission, the resident's progress notes indicated the resident's family requested the resident be admitted to the hospital and treated with intravenous medications due to past history with pneumonia. The medical provider was contacted with this information, wrote the order to send the resident to the emergency room. While in the emergency room, the resident received more chest x-rays and two antibiotics started. The resident returned back to the facility the same day.

Approximately seven weeks after admitting to the facility, the resident's progress notes indicated the resident had an appointment with a specialty physician who changed the resident's oxygen orders to allow oxygen saturation levels of 89% with the goal of less overall supplemental oxygen use. The orders also included to contact the doctor if weight gain of over five pounds, worsening leg edema, or increased SOB.

During the eighth week after admission, the resident's progress notes indicated the facility obtained an order to start a mechanical soft diet.

During the tenth week after admission, the resident's progress notes indicated the resident had new doctor's orders. The orders included to discontinue hourly oxygen saturation checks and instead check four times a day, use oxygen at two liters per minute for any oxygen saturation levels below 90% or if in distress. The same document indicated to offer the resident protein shakes three times a day between meals and could be given alone or mixed with ice cream and encourage foods easier to digest. However, after a few days the resident's progress notes indicated the resident was having trouble swallowing medications and spitting them out. After a discussion with the family, the resident switched to a pureed diet.

During the eleventh week after admission, the resident's progress notes indicated the facility obtained a new order for oxygen at 2 liters continuously. The same document indicated the family agreed to hospice services for the resident. The resident discharged from the facility to a hospice house.

During an interview, the unlicensed personnel (ULP) stated ULPs are trained and tested out by the facility to administer medications. The ULP stated when any resident refuses medications the facility trains the ULPs to make further attempts to give the medication and, if those attempts are not successful, to document the refusal and update the facility nurse. The ULP stated on occasion the resident either refused to take or spit out her medications. The ULP

stated on the resident's electronic medication administration record (EMAR) included orders to check the resident's oxygen levels and guidance for using oxygen, however the resident sometimes removed her oxygen so the staff members would try to replace it. The ULP stated the resident was unable to feed herself and staff members assisted her with meals and snacks.

During two separate interviews the facility's registered nurses stated scheduled medications are administered to the resident by trained unlicensed staff and nursing staff. The registered nurse stated when the resident refused medications the staff members would reapproach the resident three times, the refusal was then documented, and the nurse notified. The registered nurse stated the facility updated the prescriber of the resident's refusal of medications. Regarding oxygen use, the registered nurse stated the EMAR included order for oxygen use including guidelines of when to use it. The resident sometimes removed her oxygen tubing. The registered nurse stated the resident's diet changed over the course of her stay based on her energy levels and eventual decline. She stated the resident's diet progressed from a regular diet to a mechanical soft and then to a pureed diet. The resident's family member sometimes helped the resident eat and brought in homemade meals for her.

During an interview, a member of the management team stated resident had challenges with her diagnosis and decline in health, so the facility worked closely with the medical provider and the family to address the resident changing needs over time. The management team member stated the facility employs a full-time resident services coordinator who partners with the nurses and families to ensure a one person contact person to go to with concerns and keep communication open.

During an interview, the medical provider stated a face-to-face initial visit was completed the day after the resident moved into the facility. The provider stated typically a resident is seen upon admission to the facility and then once a month or if there are condition changes. The provider stated she typically is onsite at the facility two or three days a week to see residents, so she is at the facility often and she saw the resident almost every time she was onsite to address concerns brought to her attention by the facility or the resident's family. The provider stated the facility gave her timely updates regarding changes in condition, fluctuation in her weight, behaviors, or medication concerns. Additionally, the resident's family contacted her multiple times a week. The provider stated the resident's diagnoses included dementia, congestive heart failure, and aortic stenosis, which made the resident's health status very fragile. The provider stated the resident became short of breath with eating and required meal assistance along with supplemental oxygen at times. The provider stated one of the biggest challenges was the resident either refused or spit out her medications. The provider stated the topic of hospice was brought up multiple times, but the resident did not enroll until the day before she left the facility. The provider stated the discharge leave the facility was sudden from her point-of-view and was not aware of the decision until after the resident had already left for the hospice house.

In conclusion, the Minnesota Department of Health on 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:
No action required.

Action taken by the Minnesota Department of Health:
No further action required.

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		