Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203915083M
Compliance #: HL203918755C

Date Concluded: December 13, 2023

Name, Address, and County of Licensee Investigated:
Cottagewood Senior Communities
4310 55th street NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive

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 resident's diet was not followed and the resident was hospitalized with aspiration pneumonia.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident ate food which was not prescribed, it was unable to be determined how the resident obtained the food. According to facility documentation, when staff noticed a change in the resident's condition, they immediately contacted the nurse, and the resident was sent to the hospital for an evaluation. The resident received treatment and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigation included review of facility documentation and resident records. At the

time of the onsite visit, the investigator observed staff providing care to residents and assistance during meals.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included dementia and stroke with right sided weakness. The resident's service plan included assistance with all activities of daily living including eating. The service plan also indicated the resident was on a pureed (pudding consistency) diet with thickened liquids and was not to be left unattended at meals. The service plan identified for staff to complete frequent safety checks on all three shifts.

The resident's progress notes identified staff contacted the facility nurse when they noticed a change in the resident's condition. The nurse assessed the resident and noticed the resident was leaning in her chair, had abnormal lung sounds, and was minimally responsive. The resident was transferred to the hospital and diagnosed with aspiration pneumonia (an infection that develops after inhaling food, liquid, or vomit into your lungs). The resident received intravenous (IV) antibiotics and returned to the facility three days later.

The facility's internal investigation documentation identified when staff observed a change in condition, they contacted the facility nurse. However, the nurse who assessed the resident's change in condition was informed by staff that an empty bag of chips and emesis (vomit) were observed on the resident's bedding that morning. The investigation notes indicated it was unable to be determined how the resident accessed the chips, as resident would not have been able to obtain the chips or open the bag independently. Interviews conducted with staff who worked the evening prior indicated staff did not give the resident chips, did not witness the resident eating chips, and did not notice the empty chip bag.

During an interview, an unlicensed staff member stated she noticed the empty chip bag and later noticed a small amount of emesis on the resident's comforter while assisting the resident with morning cares. The staff member stated she contacted the nurse immediately but could not remember the nurse's name.

The other staff member who worked that morning could not recall details of the incident.

During an interview, the RN stated there was no documentation available to identify if the day shift nurse was notified of the open chip bag found near the resident or the emesis observed on the comforter. The RN stated staff who worked with the resident may not have correlated the open chip bag with the small amount of emesis. The RN indicated when staff noticed a change in the condition, they contacted the nurse immediately. The RN stated there were residents who wandered around the unit that could have given the bag of chips to the resident. The RN stated all staff that were interviewed denied giving the chips to the resident and no staff witnessed the resident eat the chips.

During an interview, the resident's family member stated he did not remember the specifics of this incident. The family member stated the facility always notified him with concerns and he was pleased with the care the resident received.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, unable to be interviewed.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the incident to the Minnesota Adult Abuse Reporting Center and completed an internal investigation.

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
	20391	A. BUILDING: _____ B. WING _____	C 10/25/2023

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 October 25, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL203918755C/#HL203915083M. No correction orders are issued.	0 000		