Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL254609311M
Compliance #: HL254607092C

Date Concluded: May 17, 2024

Name, Address, and County of Licensee Investigated:
Cypress Manor
16770 Wren St. NW
Andover, MN 55304
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 facility staff failed to complete turning and repositioning cares, resulting in a pressure ulcer and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When skin concerns were identified, the facility assessed, monitored, implemented interventions, and updated the resident's medical provider. The resident was hospitalized for issues unrelated to a pressure ulcer.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's therapist and mental health provider. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules,

and related facility policies and procedures. Also, at the time of the onsite investigation, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included history of a stroke, adjustment disorder with disturbances of conduct, and morbid obesity. The resident's service plan included assistance with toileting, transferring, and medication administration. The resident's assessment indicated the resident was cognitively intact, had angry outbursts, physical aggression towards staff, and a history of refusals of care.

Complaint documents indicated the facility was not turning, repositioning, or changing the resident's incontinent products, resulting in pressure ulcers and hospitalization.

The resident's medical record indicated that months prior to the hospitalization, the facility identified the resident had a redden area on his buttocks. The provider was notified, and treatments were initiated with each change in skin integrity. The resident's medical record indicated the resident was diagnosed with dermatitis (skin inflammation and irradiation) and the medical provider ordered for a home health nurse to manage wound care to the area. The resident's medical record indicated that the resident was turned and repositioned every two hours and as the resident would allow.

The resident's hospital records indicated the resident was hospitalized with aspiration pneumonia. The resident had skin fold/yeast dermatitis that was treated during the hospitalization. The resident was discharged back to the facility with home health services.

The resident's home health records indicated the resident did not have a pressure ulcer and was treated only for the area of dermatitis. The home health records indicated the resident was non-compliant with repositioning and education was provided regarding the importance in not position changes and incontinent care. The home health records indicated the resident and facility staff agreed to a plan where for the resident to be transferred back to his bed from 10:30 a.m. until noon so incontinence products could be changed.

During interviews, facility nurses stated that the resident refused to have incontinent products changed. Facility nurses educated the resident regarding the concerns of sitting in a soiled incontinent product, but he continued to refuse care. Facility nurses stated when a rash was identified the resident's buttocks, the area was assessed, the provider was updated, and orders were obtained to treat the area. Facility nurses stated that two creams were ordered but the rash did not heal. The provider then ordered a home health agency to manage the rash and care for the area.

During an interview, facility management stated the resident reported if facility staff didn't turn and reposition him; however, facility management discussed concerns with staff, reviewed facility documentation, and reviewed video footage and confirmed the resident's cares were provided as directed.

During an interview, a family member stated that the resident had concerns with wounds on his buttocks and there were concerns with the application of creams, but the wounds healed after the home health agency nurse became involved in his care.

During an interview, the resident stated he could not recall any concerns about the care provide at the facility.

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:
The facility assessed the resident’s skin, notified the provider, and implemented treatments and interventions to prevent further skin breakdown.

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
	25460	A. BUILDING: _____ B. WING _____	C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS MANOR	16770 WREN STREET NW ANDOVER, MN 55304

(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 April 8, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL254606490C/HL254608966M and HL254609311M/HL254607092C. No correction orders are issued.	0 000		