Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307836527M
Compliance #: HL307832256C

Date Concluded: June 16, 2023

Name, Address, and County of Facility Investigated:
Cottage Grove White Pines II
6950 East Point Douglas Road South
Cottage Grove, Minnesota 55016
Washington County

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

Evaluator's Name: James P. Larson
Special Investigator

Finding: Inconclusive

Nature of Visit:
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.

Allegation(s): Three facility staff/alleged perpetrators (AP#1, AP#2, AP#3) restrained and physically abused the resident, in retaliation to the resident being uncooperative, when facility staff administered oral medication while other facility staff held the resident down.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting accounts of the incident, it is unable to be determined if maltreatment occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also interviewed the resident's family. The investigation included review of the resident's medical record, nursing assessments, service plans, care plans, and progress notes. The investigator conducted an onsite visit and observed staff interaction with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included Alzheimer's disease with behavioral disturbances, dementia, and depression. The resident's service plan included safety checks, wound care, assistance with medication administration, activities of daily living, housekeeping, and meals.

Upon admission to the facility, nursing staff assessed the resident and identified the resident was cognitively impaired, unable to self-administer medications, and had a history and risk for falls. Fall and safety interventions, including scheduled safety checks, were included on the resident's service plan. Facility documentation and the resident's medical record indicated the resident also had a history of behaviors including angry outbursts and was resistive to cares.

According to complaint documents, three facility staff were witnessed restraining a resident in his wheelchair while another staff member proceeded to administer a mixture of crushed medication and pudding to the resident. The resident was then transferred to a reclining chair in the common area of the facility where a staff member held the chair in the reclined position to prevent the resident from getting up and out of the chair.

There was no facility documentation or incident report completed related to this incident and current administrative staff had no knowledge of the alleged incident.

During an interview, AP#1 recalled holding the resident in a reclined position on more than one occasion but denied physically restraining the resident or forcing medication into the resident's mouth.

During an interview, AP#2 recalled an incident where medication was given to help "settle him down" but denied that the resident was physically restrained. AP#2 stated other facility staff members were only providing verbal reassurance to de-escalate the situation. AP#2 indicated a report was submitted to the facility nursing staff detailing the incident.

AP3 declined to be interviewed.

A witness to the incident provided conflicting information of staff involved and the date and time the incident occurred.

During an interview with a resident's family member, they indicated the resident had a history of behavioral outbursts prior to admission to the facility and had no concerns with the care provided at the facility.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"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: Unable to be interviewed due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The unlicensed facility staff reported the incident to the nurse for further review. The facility conducted an internal review of events, including an interview with the resident. The resident was transferred to another facility for care.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

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
	30783	A. BUILDING: _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WHITE PINE II	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL307832256C/#HL307836527M On May 31, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL307832256C/#HL307836527M, tag identification 2310, 2330, 2350 and 2410.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide the care and services according to the acceptable health care medical or nursing standards of one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on March 13, 2023, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R1's diagnoses included, but were not limited to, Alzheimer's with behavioral disturbances, dementia, and depression. A review of complaint documents indicated facility staff/ alleged perpetrator's (AP)-1, AP-2 and AP-3 were witnessed transferring R1 to a reclining chair situated in the common area of the memory care unit. AP1 then prevented R1 from getting up and out of the chair by continuing to hold the chair	02310		

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02310	Continued From page 2 back and restrain R1 in the reclined position. When interviewed on May 31, 2023, AP-1 stated she recalls holding the resident in a reclined position against his will. A witness who reported the incident stated during an interview on June 8, 2023 that two staff members held the resident's arms down while a third administered medication against the resident's will. No facility documentation or incident reports were completed related to this incident and current administrative staff had no knowledge of the alleged incident. The licensee's Dementia Care Philosophy Policy effective date August 1, 2021 stated as an Assisted Living with Dementia Care licensed facility, White Pine & Gracewood Senior Living supports person-centered dementia services in the following manner: Philosophy of dementia care services: We are committed to treating all of our residents with dignity and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02330 SS=D	144G.91 Subd. 5 Refusal of care or services Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services.	02330		

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02330	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide care and services according to the acceptable health care medical or nursing standards when medication or treatment was forced on a competent resident who was refusing the intervention for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on March 13, 2023, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R1's diagnoses included, but were not limited to, Alzheimer's with behavioral disturbances, dementia, and depression. A review of complaint documents indicated facility staff/ alleged perpetrator's (AP)-1, AP-2 and AP-3 were witnessed restraining a resident in his wheelchair while another staff member proceeded to administer a mixture of a crushed medication and pudding to the resident. When interviewed on May 31, 2023, AP-2 recalled an incident with R1 and facility staff	02330		

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02330	Continued From page 4 which began with a verbal altercation, although date and time were unknown. R1 was offered an oral medication which was initially spit out. AP-2 then without a prescribed order to crush if needed, crushed the medication into pudding and readministered the medication while staff held the resident down. AP-2 confirmed that R1 was able to communicate his wants and needs appropriately at the time of the incident. The incident was then report to facility nursing staff. A witness who reported the incident stated during an interview on June 8, 2023 that two staff members held the resident's arms down while a third administered medication against the resident's will. No facility documentation or incident report was completed related to this incident and current administrative staff had no knowledge of the alleged incident. Review of R1's Medication Administration Record (MAR) did not include record of the refusal of the medication, crushing of the medication, or the medication administered. The licensee's Medication Management Administration Policy effective date August 1, 2021 stated ULP will chart in each resident's medication administration record any problems with medication administration, including refusals. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02330		

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02350	Continued From page 5	02350		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to treat a resident with courtesy and respect when facility staff were witnessed restraining and forcing administration of medication to one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on March 13, 2023, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R1's diagnoses included, but were not limited to, Alzheimer's with behavioral disturbances, dementia, and depression. A review of complaint documents indicated facility staff/ alleged perpetrator's (AP)-1, AP-2 and AP-3 were witnessed transferring R1 to a reclining chair situated in the common area of the memory care unit. AP1 then prevented R1 from getting up	02350		

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02350	Continued From page 6 and out of the chair by continuing to hold the chair back in the reclined position to restrain R1. When interviewed on May 31, 2023, AP-1 stated she recalled holding the resident in a reclined position against his will. When interviewed on May 31, 2023, AP-2 recalled an incident with R1 and facility staff which began with a verbal altercation and then administering medication while other staff members participated in restraining R1. AP-2 confirmed that R1 was able to communicate his wants and needs appropriately at the time of the incident. The incident was then reported to facility nursing staff. A witness who reported the incident stated during an interview on June 8, 2023 that two staff members held the resident's arms down while a third administered medication against the resident's will. No facility documentation or incident report was completed related to this incident and current administrative staff had no knowledge of the alleged incident. The licensee's Dementia Care Philosophy Policy effective date August 1, 2021 stated as an Assisted Living with Dementia Care licensed facility, White Pine & Gracewood Senior Living supports person-centered dementia services in the following manner: Philosophy of dementia care services: We are committed to treating all of our residents with dignity and respect. The facility Assisted Living Bill of Rights dated November 8, 2022 provided to staff during training and residents upon admission included	02350		

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02350	Continued From page 7 residents have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on interview and record review the	02410		

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02410	Continued From page 8 licensee failed to ensure privacy while providing care according to the acceptable health care medical or nursing standards when medication was forced on a competent resident who was refusing the intervention in the common area of a memory care unit with other residents and family member present for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on March 13, 2023, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R1's diagnoses included, but were not limited to, Alzheimer's with behavioral disturbances, dementia, and depression. When interviewed on May 31, 2023, AP-1 stated she recalled holding the resident in a reclined position against his will in a reclining chair, located in the common area of the memory care unit, with other residents and family members present. When interviewed on May 31, 2023, AP-2 recalled an incident with R1 and facility staff in the common area of the memory care unit with other residents and family members present.	02410		

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02410	Continued From page 9 A witness who reported the incident stated during an interview on June 8, 2023 that two staff members held R1's arms down and restrained R1 while a third administered medication in the common area of the memory care unit with other residents and family members present. No facility documentation or incident report was completed related to this incident and current administrative staff had no knowledge of the alleged incident. The facility Assisted Living Bill of Rights dated November 8, 2022, provided to staff during training and residents upon admission included residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		