Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333744182M
Compliance #: HL333744880C

Date Concluded: September 19, 2024

Name, Address, and County of Licensee Investigated:
Birchwood Cottages
1845 Austin Rd
Owatonna, MN 55060
Steele 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 did not provide supervision to prevent a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did fall and sustain injuries, the facility had assessed the resident appropriately and took action to seek further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's progress notes, emergency department and hospital records, facility incident report, and related facility policies and procedures. Also, the investigator made an onsite visit and observed resident to staff interactions and the resident ambulating with staff assistance.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Lewy bodies dementia (dementia affecting thinking, memory, and movement), parkinsonism (a term that refers to conditions that affects movement, such as Parkinson's disease), history of kidney stones, and hypertension (high blood pressure). The resident's medical record indicated she had a history of chronic back pain. The resident's assessment indicated she was independent with transfers and walking. The resident was oriented to person and time.

One afternoon the progress notes indicated the resident had increased back pain and the facility assessed resident. The same document indicated the facility checked the resident's vital signs and review her available pain medications. The resident had recently completed a course of antibiotics for a urinary tract infection and noted she was leaning to the right side. The facility reached out to update the resident's medical provider.

Later that same evening, the progress notes indicated the resident fell and the facility assessed the resident. The same document indicated the resident has been using a wheelchair due to increased pain, fell out of the wheelchair and the resident was found on the floor in the dining room. The facility did not identify any increased pain or injuries as a result of the fall initially.

The next day the progress notes indicated the facility assessed the resident's pain and found it was increasing. The facility contacted the resident's medical provider and sent the resident to the emergency room. The facility contacted the resident's family member who was considering transportation options. The resident transferred to the emergency room via emergency medical services later the same day.

The hospital emergency room record indicated the resident had been experiencing an asymmetric (areas failing to correspond with another area of the body) gait. On arrival to the emergency department the resident was awake and alert but disoriented. X-rays of the pelvis showed a right hip periprosthetic (fracture or broken bone occurring around a previous implant) femoral neck fracture, left 10th and 11th rib fractures, and acute L3 compression fracture.

During an interview, an unlicensed caregivers stated the resident was very mobile, enjoyed participating in all activities and was usually in the common area where staff could observe the resident.

During an interview, a family member stated prior to her fall with injury the resident had been having a significant decline. The family member stated the resident did have a history of falls especially as the resident would sit on the very edge of her bed and would slip down to the floor which was something that even occurred prior to her admission to the facility.

During an interview, nurse #1 stated on the day of the fall she observed the resident ambulating independently with leaning to her right. Nurse #1 stated she witnessed the resident walking from one side of the building to the other. Nurse #1 stated the resident was walking slower than normal appeared to be in pain and using the countertops for support when walking.

Nurse #1 stated this was out of character for the resident so she directed staff to help the resident when ambulating due to the decline and even though it was not customary for this resident to use a wheelchair may have indicated to staff to utilize a wheelchair due to pain. Nurse #1 stated the morning after the fall she had come into the facility, assessed resident, and directed for her to be taken to the emergency department.

During an interview, nurse #2 stated the resident had been recently treated for a urinary tract infection and was aware of health decline. Nurse #2 stated she had returned to the facility the evening of the fall when she observed the resident lying on her right side on the dining room floor with a pillow under her head. Nurse #2 asked staff what had happened and was told by unlicensed caregiver the resident had fallen and staff was in contact with the triage nurse. Nurse #2 stated the resident stated she was having pain, but this was not new for the resident and the resident did not appear to be in more pain than her baseline. Nurse #2 stated since the triage nurse on call had already been directing staff on what to do, nurse #2 continued to let triage nurse handle.

During an interview, a manager stated nursing was aware of resident leaning the day of the fall with injury and had been monitoring. The manager stated caregivers followed policies and protocols when the resident fell and followed direction from the on call triage nurse.

Inconclusion, 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: No, due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
No action required.

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
	33374	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1845 AUSTIN ROAD OWATONNA, MN 55060

(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 August 27, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL333744880C/#HL333744182M. No correction orders are issued.	0 000		