Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL377853581M
Compliance #: HL377853884C

Date Concluded: July 24, 2024

Name, Address, and County of Licensee Investigated:
Cascade Creek
3530 Fairway Ridge Ln SW
Rochester, MN 55902
Olmsted County

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

Evaluator's Name: Deb Schillinger RN, Special Investigator

Finding: Substantiated, facility responsibility

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 address the resident's choking risk.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility received an order to alter the resident's food by cutting into small pieces. However, this information was not provided to direct caregivers which led to two more choking episodes, the second of which led to the resident's death by choking.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. An onsite visit was made, and the investigator observed facility staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, and a history of a stroke. The resident's service plan included assistance with cueing three times daily during meals to encourage resident to take small bites, physical assistance of two facility staff members to transfer, and hourly safety checks. The resident's assessment indicated the resident required medication management, reminders for meals, and indicated the resident had no issues affecting oral intake.

The medical record indicated the resident had choking episodes three times within a 3-week period.

The first choking episode was documented in a progress note indicating the resident had choked during the evening meal. Emergency medical services (EMS) were called, and the resident was transferred to the hospital.

The medical record indicated the resident was transferred to the hospital, where treatment was received in the Emergency Department (ED), then the resident returned to the assisted living facility.

A review of the resident's medical record did not identify an incident report or an internal investigation for that first choking incident.

Four days later, the progress notes indicated the resident received a follow-up visit from the primary care provider which included specific dietary orders to cut all food to size smaller than a quarter and to obtain a swallow study.

A review of the resident's medical record indicated this order was acknowledged by the facility, however, the same review did not identify documentation indicating this information was relayed to dietary staff or unlicensed caregivers. A review of the service plan found no indication of the medical provider's specific instructions to cut food to size smaller than a quarter.

Ten days after the first choking episode, the resident choked a second time. The facility incident report indicated the resident had another choking episode when a caregiver gave the resident a cookie for an evening snack. The same report indicated the resident's face turned red and appeared to have trouble swallowing. EMS was called but the resident was not taken to the hospital.

A review of the resident's medical record indicated no service plan changes were made after this choking episode regarding the specific dietary instructions to cut food to size smaller than a quarter.

Two days after the second choking episode the facility completed the resident's assessment. This document indicated the resident had a history of choking and a referral for a speech therapy evaluation. However, this document made no reference to the resident's need to have her food cut into quarter-size bites as direct the medical provider.

On this same day, the facility updated the resident's service plan, which included encouraging the resident to take small bites and to prompt resident during meals. These interventions were scheduled at 8 AM, 12 PM, and 5 PM. The same document makes no reference to the resident's needs to have her food cut into quarter-size bites as direct the medical provider.

Six days after the second choking episode, the resident choked a third time. A facility incident report indicated the resident was found turning purple and unable to breathe at an activity event [which took place on a different unit and floor within the facility]. Unlicensed caregivers attempted the Heimlich maneuver and cardiopulmonary resuscitation (CPR) was initiated as directed by the 911 operator before EMS transported the resident to the hospital. The same document indicated the resident had a history of similar episodes and a "strong history of choking" and was given corn chips and dip at the event.

A report from the ED indicated a significant amount of food and debris was removed form resident's mouth and pharynx (throat). The resident continued to cough up copious amounts of partially chewed chips that needed to be suctioned to remove. A chest CT indicated six rib fractures resulting from CPR, then the resident developed pleural effusion (fluid buildup in the lungs) and atelectasis (collapse of a part of the lungs).

The hospital records indicated the resident died two days later.

The resident's death record indicated the cause of death was due to complications of CPR following choking on food.

During an interview, unlicensed caregiver #1 stated caregivers had no access to the resident's full care plan for directions on how to provide care for the residents. Unlicensed caregiver #1 stated it was frustrating because caregivers do not know if changes are made to care plans. Unlicensed caregiver #1 stated changes in resident cares were communicated during huddles, but not all caregivers in the facility would be present in the huddles.

During an interview, unlicensed caregiver #2 stated she was aware the resident had a choking risk due to working with the resident. Unlicensed caregiver #2 stated the staff members present at the activity event may not know the resident was at risk for choking as no information was present on the resident's care plan.

During an interview, a member of administration at the time of incidents stated the resident's dietary order was not discussed or communicated with the management team, nor was the normal process followed for order transcription.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility staff called 911 and the resident was transferred to the hospital.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Olmsted County Attorney
Rochester City Attorney

Rochester Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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: #HL377853884C/#HL377853581M On June 20, 2024, 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 38 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL377853884C/#HL377853581M, tag identification 2310 and 2360.	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=J	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 document review the licensee failed to provide care and assisted living services according to an up-to-date service plan when the licensee did not implement nor communicate R1's dietary requirements, cutting food into quarter-sized bites, after a choking episode of one of one resident (R1) reviewed. R1 had two additional choking episodes, the last of which contributed to R1's death. This practice resulted in a level four violation (a violation that results in 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's diagnoses included a history of cerebrovascular accident (CVA), and dementia. On April 19, 2024, a progress note indicating R1 had a choking episode during the evening meal. Emergency Medical Services (EMS) was called, and R1 was transferred to the hospital. A review of R1's medical record did not include an incident report for that incident. The medical record indicated R1 was transferred to the hospital, where treatment was received in the Emergency Department, then R1 returned to the assisted living facility.	02310		

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02310	Continued From page 2 The medical provider's orders dated April 23, 2024, indicated the facility was to cut R1's food smaller than size of quarter was noted as received by the facility. The progress notes dated April 23, 2024, indicated R1's medical provider ordered specific dietary orders to cut food to size smaller than a quarter and to obtain swallow study. R1's service plan on April 23, 2024, included interventions for unlicensed caregivers to remind R1 of mealtimes three times daily, physical assistance of two facility staff members to transfer, and hourly safety checks. The same document did not reference the need to cut R1's food into quarter-sized bites. A facility report dated April 29, 2024 indicated R1 choked a second time outside of the mealtime when a facility staff member gave R1 a bite of a cookie. The same report indicated R1's face turned red and appeared to have trouble swallowing. EMS was called but did not transport to the hospital. R1's service plan was updated on May 1, 2024 to included assistance with cueing three times daily during meals to encourage resident to take small bites. The same document made no reference to cutting R1's food into quarter-sized bites. R1's assessment dated May 1, 2024, indicated R1 required medication management, reminders for meals, and RN assessment indicated R1 had no issues affecting oral intake. An assessment dated May 1, 2024, indicated R1 received a regular diet, and indicated there were	02310		

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02310	Continued From page 3 no concerns affecting oral intake, a history of choking, and a referral to speech therapy. A review of the assessment did not identify reference to the medical provider's specific instructions to cut R1's food smaller than the size of a quarter. On May 5, 2024, a facility incident report indicated R1 was found turning purple and unable to breathe at an activity event. Unlicensed caregivers attempted the Heimlich maneuver and cardiopulmonary resuscitation (CPR) was initiated before emergency medical services (EMS) transported R1 to the hospital. The facility incident report indicated R1 had a history of similar episodes and a "strong history of choking". The report also indicated R1 was given corn chips and dip. On May 5, 2024, a report from the Emergency Department (ED) indicated a significant amount of food and debris was removed form resident's mouth and pharynx. R1 continued to cough up copious amounts of partially chewed chips that needed to be suctioned to remove. A chest CT indicated six rib fractures resulting from CPR, then developed pleural effusion (fluid buildup in the lungs) and atelectasis (collapse of a part of the lungs). R1's death record indicated she died two days later on the hospital. The same document indicated the immediate cause of death was complications of resuscitation-related injuries following choking on food. During an interview on June 20, 2024 at 2:16 p.m., unlicensed personnel (ULP) -A stated she had no access to the residents' full care plan for directions on how to provide care for the	02310		

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02310	Continued From page 4 residents. ULP-A stated it was frustrating because caregivers do not know if changes are made to care plans. ULP-A stated changes in resident cares were communicated during huddles, but not all caregivers in the facility would be present in the huddles. During an interview on June 20, 2024, at 2:41 p.m., ULP-B stated she was aware R1 had a choking risk due to working with R1. ULP-B stated the staff members present at the activity event may not have known R1's was at risk for choking as no information was present on R1's care plan. During an interview registered nurse (RN)-A stated diet order instructions were not in R1's service plan. RN-A stated she had recently learned diet information could be added to service plan for ULP's to acknowledge information received. The facility-provided policy title medication & treatment Orders- Implementing dated February 14, 2024, indicated that orders must be implemented within 24 hours of receipt. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by:	02360		

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02360	Continued From page 5 The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Please refer to the public maltreatment report for details. The compliance issues identified during this investigation are cited at other correction orders wthin this document.	