Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201874665M
Compliance #: HL201877940C

Date Concluded: June 21, 2023

Name, Address, and County of Licensee Investigated:
Brainerd Carefree Living LLC
2723 Oak Street
Brainerd, MN, 56401
Crow Wing County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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):
Facility staff neglected the resident when staff failed to promote healing of a pressure wound and failed to provide adequate incontinence care. The resident developed cellulitis (skin infection.)

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did have skin pressure injuries and cellulitis of the buttocks, facility licensed staff assessed the resident's skin, notified the medical provider, and implemented medical provider orders for treatment. The resident had chronic skin breakdown of the right and left upper buttock that would reoccur, heal with treatment, and reoccur again. In addition, staff provided toileting, incontinence care, and services according to the resident's service plan.

The investigator conducted interviews with facility staff members, including nursing staff, unlicensed staff, and the resident's family. The investigation included review of the resident's

records, assessments, service delivery records, hospital records, and policy and procedures related to maltreatment.

The resident resided in an assisted living facility. The resident's diagnoses included ataxia (uncoordinated movement of muscle.) The resident's service plan included assistance with transfers, staff assist to the bathroom for toileting, incontinence care, and the resident used a manual wheelchair for mobility. The resident's assessment indicated the resident was at risk for skin impairment due to incontinence, had scheduled toileting services every four hours as an intervention, and used a call pendent when needing assistance. The resident was able to verbalize his needs, at times got thoughts and words confused, and responded easily to yes and no questions.

The resident's progress notes indicated one day the resident developed a reddened area on the skin of the right buttock. The left buttock also had a healed area in the same location. The nurse assessed, staff assisted the resident with a shower, and applied barrier cream (used to protect the skin.) Three days later, the resident's medical provider assessed the resident and ordered daily cleansing with soap, water, and barrier cream application.

One month later, the resident had a change in condition. The resident was weak, sweaty, and staff checked vital signs. Staff arranged for the resident to be evaluated at an emergency room. There was a delay in notifying family of the transfer due to licensed staff in transit driving in adverse weather road conditions.

The resident's emergency room record indicated the resident admitted to the hospital for pneumonia and received treatment. The resident had a right stage 2 (partial thickness of skin loss) and left stage 1 (reddened, intact skin) buttock pressure injuries and received treatment for buttocks cellulitis. Six days later, the resident discharged to a different facility for rehabilitation.

During an interview, an unlicensed staff member stated the resident received assistance for transfers to the bathroom, incontinence care, and repositioning using a pillow to offload (used to relieve weight from an area) pressure while in his recliner. The resident chose to sleep in a recliner. At times, the resident was resistant to cares while sleeping and staff reapproached later. Staff cleansed the resident's skin daily with soap, water, and applied barrier cream.

During an interview, registered nurse (RN)-A stated the resident received scheduled assistance with transfers to the bathroom, toileting, and incontinence care every four hours.

During an interview, RN-B stated the resident had ongoing skin breakdown of the right and left upper buttock that would reoccur, heal with treatment, and reoccur again. RN-B stated this was a chronic issue and staff applied daily topical treatment for skin protection. The resident received toileting and incontinence services every four hours. During these services, facility staff cleansed the resident's skin and applied barrier cream. RN-B stated when the resident had skin

changes, a nurse assessed, updated the medical provider, and staff provided the ordered treatment. RN-B stated she assessed the resident's skin and implemented the providers treatment order.

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: No. Due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff provided services according to the service plan and followed provider orders to cleanse the resident's wound with soap, water, and apply barrier cream.

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
	20187	A. BUILDING: _____ B. WING _____	C 05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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 May 2, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL201877940C/#HL201874665M. No correction orders are issued.	0 000		