Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20455009M
Compliance #: HL20455010C

Date Concluded: March 22, 2021

Name, Address, and County of Licensee Investigated:
Pioneer Estates
8751 Preserve Boulevard
Eden Prairie, MN 55344
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, facility responsibility

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:
It is alleged: The facility neglected the client when facility staff did not monitor the client's coccyx (tailbone) pressure wound, provide pressure reducing interventions or update the provider when the client's pressure wound increased in size and the wound characteristics worsened. The client's wound advanced to a stage 4 pressure ulcer down to the bone and required hospitalization, surgical debridement, and a wound vac (vacuum assisted closure) device.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility did not ensure the client's pressure reducing interventions were maintained and that a repositioning schedule was in place for the client. The facility failed to assess and monitor the client's coccyx wound or update the provider when the wound changed and deteriorated.

The investigation included interviews with nursing staff and unlicensed staff. The investigation included a review of policies and procedures and staff training records. Several client medical

records were reviewed, including the client's record. Interviews with multiple clients found no related issues.

The client had a history of hypertension, diabetes and stroke with quadriplegia. Review of the client's facility admission assessment indicated he required full assistance with all activities of daily living, which included feeding, bathing, dressing, incontinence care and medication administration. The client used a power wheelchair, required assistance from two staff for repositioning, and a Hoyer lift for transfers. The client was alert and oriented but had aphasia (difficulty with speech) and needed extra time to express his needs.

Review of the client's admission wound evaluation completed by a facility registered nurse (RN) indicated pressure relieving interventions for the client included a pressure reduction air mattress on his bed, a pressure redistribution cushion in his wheelchair, and a repositioning schedule and incontinence care every two hours. A wound located on the client's coccyx was noted to look "good, minimal depth and had clean edges."

Review of the client's service agreement indicated nursing staff were supposed to complete the client's wound care daily and if he became soiled. The client's assessment records indicated the coccyx wound was measured once per week for a total of four weeks (four measurements). An RN documented on week one and week two, the coccyx wound showed minimal changes. From that point on, licensed practical nurses (LPNs) provided the wound care; there is no documentation that an RN visualized or re-assessed the coccyx wound after week two. Wound assessments from week three indicated an increase in wound size and depth, drainage and included undermining (when the wound edges become eroded resulting in a pocket under the skin). Wound assessments from week four indicated the coccyx wound increased again in size and in depth with purulent (pus) drainage and undermining. There is no documentation that the client's provider was contacted or that an RN assessed the wound's deterioration.

Review of photographs taken of the coccyx wound indicated a superficial stage 2 "slit" on admission. A photograph taken 4 weeks later (the day the client was hospitalized) showed a stage 4 wound crater down to the bone.

Review of hospital admission records indicated the client was hospitalized and underwent surgical wound debridement, and a wound vac was placed on the wound.

Review of a facility media advertisement indicated the facility supports clients with complex cares and high acuities. The facility advertised it had highly trained and experienced staff that specialized in complex cares and supported high acuity clients with customized individual care plans.

During interview, an RN that completed one of the client's early assessments stated any wound changes, such as new or increased redness, drainage, or odor should have been reported right away.

During interview, staff members stated the client refused to lay down and wanted to stay in his wheelchair all day. The staff members also agreed it was the client's right to refuse. The client's record did not contain documentation of the client's refusals or interventions used by staff members because of the refusals.

During interview, a family member stated the client preferred to stay up in his wheelchair for the day which meant he had to off-set pressure on his coccyx area by tilting the wheelchair in various degrees throughout the day, ensuring his cushion was properly inflated and good incontinence care. The family member stated the family previously cared for the client at home for ten months without any pressure wound occurrence. The family member said the client could not reposition himself or the wheelchair and relied on staff for all activity and offloading pressure. The family member stated this was communicated multiple times to staff during the client's stay at the facility.

During interview, the nurse manager stated that the nurse practitioner was informed of the client's wound's deterioration and that an order for a wound consultation was obtained five days before the client was hospitalized. The nurse manager also stated there were no updates to the client's interventions or a change in condition assessment completed by an RN while the client waited for the wound care visit.

During interview, the visiting home care nurse stated she first saw the client's wound the day the client was sent to the hospital. She stated the sight of the wound "took her breath away" and "you could place your fist in it." She stated the wound was green, sloughy, draining, and foul smelling. The visiting home care nurse said the dressing used on the client's wound was not appropriate, and the client had no moisture containment from incontinence.

In conclusion, neglect was substantiated. The facility was responsible for the maltreatment.

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:

(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. The client is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Following the incident, the facility reviewed the incident and provided training for all staff on policies pertaining to wound and skin care, positioning, and therapeutic diets.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc: The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Eden Prairie City Attorney
Eden Prairie Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20455	A. BUILDING: _____ B. WING _____	C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER ESTATES OF EDEN PRAIRIE	8751 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On February 9, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20455010C/#HL20455009M. At the time of the investigation, there were #7 clients receiving services under the comprehensive license. The following correction order is issued for #HL20455010C/#HL20455009M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 325		

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0 325	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of three clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On March 12, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details.	