Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20551001M
Compliance #: HL20551002C

Date Concluded: October 18, 2022

Name, Address, and County of Licensee Investigated:
Woodbury Estates
2825 Woodlane Drive
Woodbury, MN 55125
Washington County

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

Evaluator's Name: Stacia Hansen, 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.

Initial Investigation Allegation(s):
The facility neglected a resident when staff members did not know if there were any orders to provide care to her right foot after she had been discharged from the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure a nursing assessment was performed after the resident returned from the hospital. As a result, the resident experienced severe pain and ultimately an above the knee amputation.

The investigator conducted interviews with facility staff members, including nursing staff. The investigator contacted emergency personnel. The investigation included review of resident

records, policies and procedures, complaints/grievances, and hospital records. Also, the investigator toured the facility and observed resident/staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, diabetes, and hypertension. The resident's service plan included assistance with bathing, toileting, transferring, medication administration and blood glucose monitoring. The resident's assessment indicated she needed hands-on assistance with dressing and applying compressions stockings/wraps.

The resident's progress notes indicated she fell the previous day and a family member was going to take the resident to urgent care to have her foot examined. The progress note indicated the next day the resident was hospitalized and treated with intravenous (IV) antibiotics for diverticulitis (an infection in a small pouch in the digestive tract).

The resident's hospital records indicated an ACE wrap was applied during this hospitalization and returned to the facility after four days.

The progress notes indicated four days after the resident returned to the facility, the nurse found a wound on the resident's right foot and noted her toes were discolored (black and bluish) so later in the afternoon the resident was sent to the hospital for further evaluation of her right foot.

Hospital records indicated the resident presented to the emergency department for treatment of ischemic (lack of adequate blood flow from the heart to the foot) right foot. The hospital records indicated an ACE wrap had been previously placed for comfort measures for a sore ankle. The hospital records indicated the ACE wrap was removed at the facility and they discovered the underlying wound. The same documents indicated the resident's foot was cold to touch and cyanotic (a bluish discoloration of the skin from inadequate oxygenation of the blood) on exam.

The resident's provider note indicated the resident was sent to the hospital for her right foot wound an ultrasound showed an occlusion of the right femoral artery and tibial arteries. The provider note indicated a vascular specialist recommended conservative treatment rather than amputation at that time. However, the provider note indicated the resident's pain progressed and, upon reevaluation two weeks later, right above the knee lower extremity amputation was planned.

During an interview, the nurse stated when the resident returned to the facility it was one of the busiest times during the shift, so she checked her blood sugar and vital signs. The nurse stated she did a "quick" assessment and does not recall seeing an ACE wrap on the resident's foot.

During an interview, another nurse stated the resident was complaining of foot pain when a staff member noticed the resident's black toe and brought her to the nurses' station.

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, due to dementia diagnosis
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility sent the resident to emergency department for further evaluation.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20551	A. BUILDING: _____ B. WING _____	C 08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	**2825 WOODLANE DRIVE WOODBURY, MN 55125**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL20551002C/#HL20551001M On August 29, 2022, 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 61 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction orders are issued for #HL20551002C/#HL20551001M, tag identification 1620, 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 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 surveyors ' 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 subd. 1, 2 and 3	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment following a change of condition (hospitalization) for one of one residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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	01620		

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01620	Continued From page 2 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1's diagnoses included dementia, diabetes, and hypertension. R1's service plan, dated December 7, 2021, indicated R1 received assistance with bathing, toileting, transferring, medication administration and blood glucose monitoring. R1 was hospitalized from March 3, 2022, through March 7, 2022. R1's progress note dated March 4, 2022, at 10:44 p.m. indicated R1 discharged back to the facility around 5:30 p.m. and the registered nurse (RN)-D collected vital signs from R1. R1's record lacked a current and up-to-date assessment following R1's hospitalization and change of condition. R1's progress note dated March 11, 2022, at 1:19 p.m. indicated the licensed practical nurse (LPN)-B found R1's right foot and toes were discolored (black and bluish) and had a wound. R1's progress note dated March 11, 2022 at 4:04 p.m. indicated R1 was sent to Woodwinds for further evaluation of her right foot. R1's hospital records dated March 11, 2022 at 4:16 p.m. indicated R1 presented to the emergency department for treatment of ischemic right foot. The hospital records indicated an ACE wrap had been previously placed for comfort measures for a sore ankle. The hospital records indicated the ACE wrap was removed at her	01620		

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01620	Continued From page 3 facility and they discovered the underlying wound. Also, on exam the resident's foot was cold to touch and had cyanosis according to hospital records. During an interview on September 6, 2022, at 10:05 a.m., registered nurse (RN)-D stated when the resident returned to the facility it was one of the busiest times during the shift so she checked her blood sugar and vital signs. RN-D stated she did a "quick" assessment and does not recall seeing an ACE wrap on the resident's foot. The licensee's Clinical Assessment Guide, dated April 2021, indicated a nursing assessment is required for change in condition/hospitalizations. Time Period for Correction: 21 (twenty-one) days	01620		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (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 in accordance with accepted health care standards for one of one resident (R1) reviewed ischemic right foot when R1 developed a right foot wound and the licensee failed to create and implement new care interventions to address foot care. As a result, R1 experienced severe pain and a right above the knee amputation.	02310		

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02310	Continued From page 4 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 medical record was reviewed. R1's diagnoses included dementia, diabetes, and hypertension. R1's service plan, dated December 7, 2021, indicated R1 received assistance with bathing, toileting, transferring, medication administration and blood glucose monitoring. R1's nursing assessment dated March 4, 2022, indicated R1 needs hands on assistance with dressing and/or laying out clothes/items, buttoning shirts, putting on or taking off clothing and applying TED/compression stockings/wraps. R1 was hospitalized from March 11, 2022 through March 19, 2022. R1's record lacked documentation of skin checks or removal of ACE wrap on R1's right ankle/foot. R1's progress note dated March 11, 2022, at 1:19 p.m. indicated the licensed practical nurse (LPN)-B found R1's right foot and toes were discolored (black and bluish) and had a wound. R1's progress note dated March 11, 2022, at 4:04	02310		

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02310	Continued From page 5 p.m. indicated R1 was sent to Woodwinds for further evaluation of her right foot. R1's hospital records dated March 11, 2022, at 4:16 p.m. indicated R1 presented to the emergency department for treatment of ischemic right foot. The hospital records indicated an ACE wrap had been previously placed for comfort measures for a sore ankle. The hospital records indicated the ACE wrap was removed at her facility and they discovered the underlying wound. Also, on exam the resident's foot was cold to touch and had cyanosis according to hospital records. R1's provider note dated April 4, 2022, at 2:30 p.m. indicated when the resident was sent to the hospital for her right foot wound an ultrasound showed an occlusion of the right femoral artery and tibial arteries. The provider note indicated a vascular specialist recommended conservative treatment rather than amputation at that time. The provider note indicated R1's pain progressed then she was reevaluated by a vascular provider 2 weeks later and planned to go forward with a right above the knee lower extremity amputation. During an interview on September 1, 2022, at 1:02 p.m., licensed practical nurse (LPN)-B stated R1 was complaining of foot pain when a staff member noticed the resident's black toe and brought her to the nurses' station. During an interview on September 6, 2022, at 10:05 a.m., registered nurse (RN)-D stated when the resident returned to the facility it was one of the busiest times during the shift so she checked her blood sugar and vital signs. RN-D stated she did a "quick" assessment and does not recall seeing an ACE wrap on the resident's foot.	02310		

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02310	Continued From page 6 During an interview on September 8, 2022, at 3:50 p.m. an emergency personnel (EP)-E stated she responded to a 911 call at the facility for a resident with foot pain. EP-E stated staff members at the facility did not know what the discharge instruction were from the hospital and if the resident was responsible to care for the bandage on her foot or not. The licensee's document titled Change in Condition, dated December 2019, indicated a nursing assessment is required for an acute care transfer due to an acute change resulting in an admission to the hospital. Also, indicated notification of medical practitioner, review and revise service plan. Time Period for correction: 7 (seven) 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the	02360		

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02360	Continued From page 7 maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		