Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL271835961M
Compliance #: HL271838564C

Date Concluded: February 12, 2025

Name, Address, and County of Licensee Investigated:
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN 55112-6277
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lissa Lin, 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 he developed pressure ulcers on his ankle and staff failed to follow his plan of care. The resident's leg infection worsened, and he required a leg amputation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff followed the resident's service plan, which indicated he was prone to "open areas" on his skin and needed treatment. The nurse trained unlicensed personnel (ULP) to perform skin checks and basic wound cares for the resident, which they already performed on existing open areas of his skin. ULP notified the nurse when they observed wounds on his left foot and leg. The nurse notified the resident's primary care provider (PCP) and who assessed the resident's foot and leg wounds and coordinated months of cares with a skilled wound nurse and a vascular surgeon.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident, his family member and the complainant. The investigation included review of the resident's records, wound care records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, left sided weakness post stroke, chronic pain, and edema. The resident's service plan included assistance with all activities of daily living (toileting, showers, mobility) and treatment for open areas of his skin. The resident used a wheelchair and scooter for mobility and a quad cane and an AFO (ankle foot orthotic) brace for shorter distances. He also used an EZ stand (mechanical standing lift) device to help with transfers. The resident was followed by a pain clinic and received physical and occupational therapy visits from a home care service.

The resident made his own decisions but had a power of attorney (POA) to manage his finances. The nurse assessed him as lacking the ability to recognize or protect himself against health and safety risks. He frequently declined cares and needed cueing from staff to complete cares and tasks.

Review of weekly skin assessments indicated staff were monitoring and treating existing skin issues on the resident. He had a light pink spot on his right ear, a bunion on his right foot and a light pink area of skin on his sacrum. He received hydrocortisone cream applied three times daily to his ear, and calmoseptine ointment applied three times daily to the sacral area and as needed.

One day during a skin assessment, ULP observed the resident's left foot was swollen. He had a 2.2 centimeter (cm) red line across the top of his foot, two partially scabbed sores, both measuring approximately 2 x 1 cm and a 2 x 2 cm "upside down V shaped" open area on his lower left calf. ULP notified the nurse. The nurse contacted the resident's PCP and requested a wound care nurse to assess his left foot. The nurse indicated the resident's AFO brace may have caused the new reddened and scabbed areas on his skin; an orthotics provider had adjusted the AFO brace months ago but the neither the resident nor ULP reported issues with the brace not fitting properly. The nurse instructed ULP to stop using the AFO brace and ordered heel protectors for him. There was conflicting information on how long the resident wore his AFO brace beyond daily transfers.

The resident's treatment and medication administration records included new wound cares orders from the resident's PCP, the wound care nurses and vascular surgeon. The nurse cleaned and dressed his wounds per orders.

During the next few months, the resident's wounds were monitored and treated by the facility nurse, visiting wound care nurses, his PCP and a vascular surgeon. Despite the wound treatments, which included debridement and antibiotics, the resident's "chronic left leg

wounds" did not heal. Three open areas developed on his left foot: two stage 2 (shallow, partial skin open) pressure sores and one stage 4 (all layers of skin damaged) pressure sore on his ankle, which was later diagnosed as an arterial ulcer. A consult with a vascular surgeon was arranged.

During an interview, the resident said when he broke his left leg and ankle a few years ago, a surgeon placed a rod from his left ankle up to just below the knee to repair the multiple breaks. After the surgery his left foot was often swollen. He said he wore an AFO brace for years. It was used during transfers and to walk short distances. He said he liked wearing it throughout the day because he could move around more independently with it. He said the medical supply provider adjusted the AFO brace, but he did not recall how long ago that was. He did not notice any discomfort or skin problems after the adjustment. He did not know how the ankle wound started but said facility staff observed them during a skin check and notified the nurse. His PCP ordered daily and as needed wound cares and wrote an order for a skilled wound care nurse to assess and treat his open areas. The resident said he had weeks of wound cares and antibiotics, but his top left foot wound grew larger, and he had some type of bacterial infection. He was referred to a vascular surgeon who suggested he consider a below the knee amputation because bacteria and metal particles from the infected surgical hardware could enter his blood stream and be fatal. The resident said overall the facility staff took good care of him.

During an interview, the nurse said ULP acted immediately when they saw the reddened and scabbed areas on his left foot. The nurse notified the physician and instructed ULP not to use his AFO brace. They already repositioned the resident every two hours and did weekly skin checks and continued those cares. Wound care nurses visited the resident twice a week for wound cares and they made almost all the decisions on his wound care. The nurse said after many weeks, the wound care nurses told her the treatments were not working and the resident's foot was not improving. They wanted the resident to see a vascular surgeon. The nurse said resident's family had concerns about his declining mobility and his wounds. It was a struggle sometimes because the resident was his own decision maker, and the family did not always agree with his decisions and actions. The nurse said she updated his family when she information for them. She did not know if the wound care nurses also contacted them.

During an interview, another nurse said ULP assisted the resident with putting on the AFO brace daily and were good about reporting skin changes or fit issues with his AFO brace. The nurse said reddened and scabbed areas could develop quickly with circulation problems. She said staff addressed his skin breakdown as soon as it was reported. She was at the facility the day ULP observed his wounds. She measured them and notified the PCP. She started treatment with triple antibiotic ointment and a Telfa pad, then wrapped his foot with Kerlix and secured with tape. She did this daily until a wound care nurse arrived a few days later and implemented their own wound cares twice weekly. The facility nurse still changed his dressing once a week until the wound care nurses took over all of the resident's wound cares. Facility staff were still responsible for ensuring his dressings stayed intact, clean and dry.

During an interview, the resident's family member said the resident's leg never completely healed after surgery a few years ago; his leg was always swollen and painful. He was treated for a left foot wound two years ago. She said the staff at the facility were "ok" and treated the resident's current foot wound, but they did not always change his wound dressings. The family member said the facility's nurses and the wound care nurses did not keep her or other providers informed on what happened with the resident's foot. Because of his foot wound, a surgical procedure scheduled with his pain clinic for a trial spinal cord stimulator placement was cancelled. The family member said the resident was neglected.

The resident moved to a new facility and had a below the knee left leg amputation.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility treated existing skin issues and monitored the skin. ULP notified nurse of new skin breakdown. The nurse notified the PCP and implemented new wound cares. Skilled wound care nursing provided cares. The facility consulted with the vascular surgeon.

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
	27183	A. BUILDING: _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 January 15, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL271838564C/#HL271835961M. No correction orders are issued.	0 000		