Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL289899102M
Compliance #: HL289897421C

Date Concluded: March 12, 2025

Name, Address, and County of Licensee Investigated:

Lilac Homes Assisted Living
2615 Parkview Drive
Moorhead, MN56560
Clay County

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the facility failed to ensure she received appropriate treatment for a toe wound. The resident was hospitalized/treated for osteomyelitis (a severe bone infection) .

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had chronic recurring cellulitis infections of the toe. The resident's toe cellulitis had been treated by multiple providers prior to having a wound debridement/culture which identified 2 strains of MRSA (bacteria) in the wound. The resident was hospitalized 7 days later with no signs of acute infection. The facility followed the residents plan of care and physician orders for care of the residents' toe.
Additional concerns which were not alleged maltreatment were reviewed including transfers, toileting, and medication administration.

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(s), hospital records, facility incident reports, and related facility policy and procedures. Also, the investigator observed the resident's toe wound and other resident's and staff at the facility.

The resident was admitted to the assisted living facility secure memory care unit approximately 4 years prior with diagnoses including Alzheimer's Disease, dementia, peripheral vascular disease, and cellulitis of the second toe.

A resident assessment dated December 20, indicated the resident had moderate cognitive impairment and was recently diagnosed with cellulitis of the second toe on her left foot on August 26. The assessment identified the wound was chronic/recurring in nature. At the time of the assessment the resident's toe had a healing scab that was not red.

The resident's care plan identified the resident had a history of cellulitis infection of the left second toe.

The resident's medical record indicated she received treatment for chronic recurring cellulitis infections of the left second toe including one time in 2022, and five times in 2023.

A hospice recertification evaluation form indicated the resident was seen for continuation of hospice services and indicated the resident required antibiotics to treat a recurring cellulitis infection of the resident's left second toe.

On August 26 an after-visit summary (AVS) indicated the resident was again seen for a cellulitis infection of the left second toe and given an antibiotic injection and prescribed oral antibiotics. The AVS included instructions for wound care/dressing changes.

On September 16 (22 days later) a physician's order included new orders for wound care/dressing changes.

On October 30, a progress note indicated the resident was seen by the provider and indicated the toe appeared to be healed but wanted a band aide on it just in case.

The resident record included documentation of weekly skin/wound monitoring and supervision of staff completing dressing changes to ensure competency with no concerns identified. The resident's record indicated weekly wound monitoring was completed and indicated the toe wound was scabbed and healing with no signs or symptoms of infection noted.

5 days later a progress note indicated the nurse received a message from the resident's family member that the resident's left second toe was red and inflamed, with possible drainage noted.

Nursing advised the family to bring the resident in for evaluation due to history of recurring infection in that toe.

An emergency department (ED) AVS indicated the toe appeared like it could possibly be infected, and the resident was given an antibiotic injection, and was also prescribed oral antibiotics. The AVS indicated an X-ray was completed with no concerns for osteomyelitis at that time.

On December 31, a provider contact communication form included orders for daily wound care/dressing changes of the left second toe wound.

On January 8, the resident was seen to establish care with a new provider and included a review of the resident record which indicated the resident had history of a chronic ulcer with cellulitis infections of the left foot second toe, most recently treated in December. An assessment of the resident's toe showed a deformity of the left second toe with a chronic open sore and clear drainage present. The resident was again prescribed oral antibiotics for 7 days.

2 days later a weekly skin/wound monitoring note indicated the toe wound previously diagnosed cellulitis was slightly swollen with a small open area in the middle of the wound and a small amount of slough and minimal drainage noted. The note indicated dressing changes were completed as ordered. Another weekly skin/wound monitoring indicated the toe was slightly swollen, with a slight open area in the middle of the wound, and no drainage noted. The note indicated dressing changes were completed as ordered.

On January 22, a provider progress note indicated the resident was seen by podiatry for the toe wound. The note indicated the resident was diagnosed with osteomyelitis and prescribed oral antibiotics. The note indicated family reported the resident's infection improved while on antibiotics but deteriorated once the medication was discontinued.

On January 29, a podiatry progress note indicated the resident's wound was debrided to remove tissue and bone. A wound culture following the procedure identified the resident had 2 strains of MRSA in the wound. The resident returned to the facility with orders to keep the bandage in place for 2 days, then provide daily bandage changes after that. The note indicated oral antibiotics were again prescribed to treat the infection.

2 days later a weekly skin/wound monitoring indicated the debride wound was about 0.8 centimeters (cm) x 0.8cm in size, with slough noted to about 1/4 of wound bed, and pink tissue was also noted. The wound had no drainage at time of dressing change, and no odor was noted. 5 days later another skin/wound assessment indicated the wound was smaller with minimal drainage, no signs of infection were noted.

The residents Medication and Treatment Administration Record indicated antibiotics and wound care/dressing changes were provided as ordered.

7 days later a progress note at the time of admission to the hospital indicated although an Xray showed evidence of osteomyelitis the resident had no signs or symptoms of acute infection including redness, edema, purulence, or malodor. The note indicated the resident was admitted to the hospital for management of the infected wound.

The hospital record included a radiology report which indicated an MRI was completed and confirmed second toe osteomyelitis and cellulitis infection with abnormal bone marrow edema.

Another hospital progress note indicated infectious disease was consulted who documented the resident had been seen and treated for cellulitis several times prior to being referred to podiatry and diagnosed and subsequently hospitalized with osteomyelitis. The note indicated despite being given oral antibiotics the wound worsened until she was admitted with the non-healing wound. The note indicated the resident had a polymicrobial non healing wound that despite best efforts including adequate antibiotic treatment and wound care may not heal.

The hospital record indicated the resident was admitted to the hospital for 11 days and received IV antibiotics and wound care, then was discharged back to the facility.

When interviewed facility leadership and nursing staff stated the resident had chronic recurring infections of her left second toe since admission, with no concern of worsening infection prior to her admission to the hospital. Leadership and nursing staff interviewed indicated they had no concerns for neglect of the resident's toe wound and indicated they followed providers orders for treatment of the chronic recurring wound.

When interviewed an unlicensed personnel (ULP) stated the resident had a recurring sore on her toe that never really healed. The staff stated they followed providers orders and provided care to the resident according to her orders and plan of care.

When interviewed another ULP stated the resident had a recurring infection of the toe since admission to the facility that would come and go but never completely healed. The ULP stated she was trained and evaluated on the resident's dressing changes to ensure she was completing them correctly. The ULP stated the toe wound looked no different prior to the resident being hospitalized and indicated they would report any changes or concerns to the nurse immediately.

When interviewed the family member stated the resident had a hammer toe deformity with a chronic callous area, but repeatedly denied the resident had any history of being treated for recurring chronic infections of the left second toe. The family member stated providers in the hospital told her the residents toe infection could have been prevented with the appropriate wound care.

Additional concerns reviewed indicated the resident was assessed by physical and occupational therapy who indicated the resident required use of a full body Hoyer lift for all transfers for safety. The resident was being toileted according to the individualized assessment. The resident's use of as needed (PRN) medications during the time of the investigation was reviewed with no concerns.

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: N/A

Action taken by facility:
The facility provided skin/wound monitoring, medication administration services, and wound care as ordered by a provider.

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
	28989	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOMES ASSISTED LIVING	2615 PARKVIEW DRIVE MOORHEAD, MN 56560

(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 February 20, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL289899102M/#HL289897421C. No correction orders are issued.	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.	