Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL29536001M
Compliance #: HL29536002C

Date Concluded: April 21, 2022

Name, Address, and County of Licensee Investigated:
Caring Nurses, LLC
7714 Brooklyn Boulevard Suite 204
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Laura DuCharme, RN
Special Investigator
Paul Spencer, 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(s):
It is alleged: The facility neglected the resident when the facility staff failed to assess the resident after the resident developed a pressure injury. The resident's pressure injury grew progressively worse, became infected, and required hospitalization.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The resident refused to let the nurses assess his pressure injury. However, the facility neglected the resident when the facility's nursing staff delegated unlicensed personnel (ULP) to request an order for a referral from the resident's physician and did not follow-up on the referral to ensure the resident received care and services to address his sacral wound. The facility also failed to supervise the

ULP to ensure the concern for the resident's pressure injury reached the resident's physician timely and effectively.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical record and on onsite visit.

The resident's diagnoses included a history of a gunshot wound, spinal cord injury, and paraplegia. The resident's assessment indicated he was alert and oriented, could move his arms but paralyzed from the waist down. The resident required, assistance with incontinence of bowel, a total assist lift for transfers and used a wheelchair for mobility. While the resident had an abdominal wound requiring a dressing change upon admission to the facility, his assessment identified no other skin concerns such as open areas or wounds requiring dressing changes. The resident's medical record indicated he performed self-catheterization for urine.

During the resident's second week at the facility, the resident's progress notes indicated nurse #1 offered to assess the resident's wound, but he refused. The same note indicated nurse #1 delegated the "care coordinator" (ULP) to call a clinic to request a wound care referral and a physical and occupational therapy consult due to resident's refusal to get out of bed.

During the resident's third week at the facility, the resident's ULP note indicated ULP #1 observed the "wound" on the resident's "butt" (sacrum) was "spreading and red". The same document indicated ULP #1 called the resident's physician and awaited a call back. The same note indicated the clinic said they would send out a wound care nurse.

During the next two weeks, the resident's progress notes and skin and body audit forms indicated the resident's sacral wound continued to persist. Nurse #1 continued to delegate to the ULP to contact the clinic because no wound care nurse referral had been received nor established. Neither nurse #1 nor nurse #2 (the nurse supervisor) assessed the resident's wound directly.

During the resident's sixth week at the facility, the resident's ULP note indicated ULP #2 called the resident's physician to request a wound consult. The resident had an appointment over the phone and after the appointment the physician said "they" will work on getting a home care agency. The resident's facility clinic form indicated the resident had an appointment with his physician. The form included an area labeled "reason(s) for today's visit" with the word "follow-up" and indicated ULP #1 signed the form. The form did not include reference to the resident's sacral area or pressure injury.

Over the next few weeks, the facility continued to fail to establish a wound care referral or assessment of the resident's sacral wound to provide treatment. Nurse #1 continued to delegate to the ULP to follow up with the resident's provider with no outcome.

During the resident's tenth week at the facility, the resident's ULP note indicated ULP #1 was present during a phone visit with the resident's physician. The same note indicated the resident's physician ordered a wound care nurse, occupational and physical therapy.

During the resident's eleventh week at the facility, the resident's progress notes indicated nurse #1 encouraged him to allow an assessment for his open area. The same note indicated nurse #1 explained the importance of wound cares and the risk of infection, but the resident refused. Nurse #1 delegated to the ULP to follow-up on the referral.

During the resident's twelfth and final week at the facility, the resident's progress notes by nurse #2 indicated the facility sent the resident to the emergency department after emesis and loose stools. The same document indicated the resident admitted to the hospital.

The resident's hospital surgery note indicated the resident had osteomyelitis (an infection of the bone) and a large pressure injury. The same document indicated the resident said his caregivers did some dressing changes to the wound. The same document described the wound as a stage four pressure injury to the sacrum with exposed bone in the wound base accompanied by an image of the resident's sacral wound. The resident's hospital record indicated the resident admitted to the hospital with diagnoses including sacral pressure ulcer, sepsis (infection of the blood stream), and osteomyelitis. Upon admission, the hospital record indicated the resident had a diagnosis of sepsis with possible "port of entry" as the sacral pressure injury and an image showing a wound described as concerning for bone involvement and osteomyelitis.

The resident's death record indicated the resident died during the same hospital stay and listed the cause of death as including complications of sepsis due to a sacral ulcer.

During an interview, ULP #1 stated she worked as an "assistant coordinator", and she was not a nurse. ULP #1 stated the resident's skin on his bottom started to breakdown within a week or two after he was admitted to the facility. ULP #1 stated she called the resident's physician and the clinic to get a home care nurse to see the resident. ULP #1 stated there was a delay in getting a home care nurse because she did not know it required a referral. ULP #1 stated she was using dry bandages and an over-the-counter cream recommended by the clinic on the resident's sacral wound. ULP #1 stated she texted picture to the registered nurse supervisor, nurse #2. ULP #1 stated nurse #2 said she should not have taken on the responsibility of calling people on her own and should have involved nurse #2 sooner. ULP #1 stated the wound care nurse (nurse #1) knew about the wound, but nurse #1 said she could not just take over but needed something from the clinic.

During an interview, ULP #2 stated she worked as a "care coordinator." ULP #2 stated the facility had a wound care nurse [nurse #1] and she offered to assess the resident's wound, but the resident refused. Nurse #1 delegated to ULP #2 to contact the resident's physician. ULP #2 stated the only physician the resident was willing to see was the physician who ordered his pain medicine.

During an interview, nurse #1 stated she was the wound care nurse for one resident [a different resident.] Nurse #1 stated she did not have much to do with the resident. She said she was told once by staff the resident had something to look at, but the resident refused to allow an assessment. Nurse #1 stated she informed the nurse #2 she should try to let the physician know. Nurse #1 stated this was the only time she had anything to do with the resident.

During an interview, nurse #2 stated ULP #1 reached out to the resident's physician for orders. Nurse #2 stated they did not obtain orders for wound care, but rather a wound care referral. Nurse #2 stated nurse #1 attempted to assess the resident but he refused. Nurse #2 stated nurse #1 works with another resident who has chronic wounds.

During an interview, the licensed assisted living director (LALD) stated the facility has a wound care nurse who assesses wounds (nurse #1). The LALD stated the wound care nurse provides wound care or delegates the wound care to the ULPs. The LALD stated the wound care nurse delegated ULP #1 to contact the residents' physician to get an order for the resident to be seen in a wound clinic.

During an interview, the resident's physician stated he had multiple appointments with the resident but there were no concerns raised regarding a wound until the last appointment [during the tenth week of the resident's stay at the facility]. The resident's physician stated the last appointment occurred via telephone and was the first time the facility informed him of an open pressure injury, which he could not assess via a telephone visit. The resident's physician stated he sent a referral for home care wound care because of the last appointment.

During an interview, nurse #3, a nurse employed at the clinic where the resident's physician worked, stated if the clinic receives a phone call regarding a resident, the clinic documents and forwards it to the provider/physician. Nurse #3 stated there were phone calls from the facility regarding the resident, but no phone calls concerning a wound. Nurse #3 stated the only referral in the resident's record occurred during the last appointment with the resident.

In conclusion, 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:
(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; deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: No action taken.

Action taken by the Minnesota Department of Health:
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. You may also call 651-201-4890 to receive a copy via mail or email.
The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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: #HL29536001M/#HL29536002C On September 28, 2021, through September 29, 2021, 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 four residents receiving services under the provider' s Assisted Living with Dementia Care license. The following correction order is issued for #HL29536001M/#HL29536002C, tag identification 1410.	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.	
01410 SS=J	144G.62 Subd. 2 Delegation of assisted living services	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 1 (a) A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The assisted living facility must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services subject to appropriate Minnesota practice acts when the licensee delegated unlicensed personnel (ULP) to request an order for a referral from the resident's (R1) medical doctor (MD)-G. The licensee also failed to provide supervision to ensure the request for a referral and concern for R1's pressure injury was effectively communicated to the MD-G. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The Nurse Practice Act, Minnesota Statute Section 148.171, dated August 1, 2013, indicated the registered nurse (RN) scope of practice	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 2 included implementing interventions delegated, ordered, or prescribed by a licensed health care provider. The same document indicated "delegation" means the transfer of authority to another nurse or competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. The same document indicated "supervision" means guidance means guidance by the RN including the initial direction, setting expectations, directing activities and course of action, evaluating, and changing a course of action. Based on the National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate any activity which requires clinical reasoning, nursing judgment, or critical decision making. R1 admitted on June 14, 2021. R1's diagnoses included a history of a gunshot wound, spinal cord injury, and paraplegia. R1's Baseline Assessment dated June 19, 2021, indicated he alert and oriented, could use his arms to participate in cares but was paralyzed from the waist down. The same document listed R1 as "totally dependent" for dressing, toileting, bathing, and mobility while requiring a total assist lift for transfers and a wheelchair. The same document indicated R1 had an abdominal wound, which required dressing changes. The same document identified no other skin concerns such as open areas or wounds requiring dressing changes. R1's medical record indicated he performed self-catheterization for urine. R1's progress note dated June 23, 2021, indicated RN-C offered to assess R1's wound but he refused. The same note indicated RN-C	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 3 delegated the "care coordinator" to call a clinic to request a wound care referral and a physical and occupational therapy consult due to resident's refusal to get out of bed. R1's assessment dated June 28, 2021, indicated R1 was incontinent of stool and required assistance with changing his incontinence pad. The same document indicated R1 refused cares such as repositioning. R1's Care Coordinator note dated June 28, 2021, indicated ULP-A observed the "wound" on R1's "butt" (sacrum) is "spreading and red". The same document indicated ULP-A called MD-G and awaited a call back. The same note indicated the clinic said they would send out a wound care nurse and OT [occupational therapy]. R1's progress note dated July 7, 2021, indicated R1 refused to let RN-C assess his sacral area. The same note indicated the care coordinator was to call a clinic for a wound referral. R1's Skin and Body Audit dated July 14, 2021, indicated with an "X" and the words "open red wound" on R1's sacral area. The same document indicated the area for Nurse Assessment and Treatment Nurse was blank. R1's Care Coordinator noted dated July 19, 2021, indicated ULP-B called MD-G to request a wound consult. The same note indicated R1 had an appointment over the phone and after the appointment the MD-G said "they" will work on getting a home care agency. R1's Clinic Referral dated July 23, 2021, indicated R1 had a MD-G appointment the same day. The form included an area labeled "reason(s) for	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 4 today's visit" with the word "follow-up". The same document indicated ULP-A signed the form. The same document did not include reference to R1's sacral area. R1's progress notes dated August 4, 2021, indicated RN-C offered to assess R1's wound but he refused. The same note indicated RN-C "delegated again" the care coordinator to contact providers and follow-up on a wound care referral. R1's progress notes dated August 11, 2021, indicated RN-C offered to assess R1 but he refused. The same noted indicated RN-C delegated to the care coordinator to follow-up on a referral and to request the referral on R1's upcoming appointment on August 18. R1's Care Coordinator note dated August 18, 2021, indicated ULP-A was present during a phone visit with MD-G. The same note indicated MD-G ordered a wound care nurse, OT, and physical therapy. The same note indicated "he" [the MD-G] was going to send a referral for the nurse to come out. R1's progress note dated August 18, 2021, indicated R1 had his appointment with his MD-G. The same note indicated the care coordinator updated RN-C saying a wound care nurse would be out as soon as available. R1's progress notes dated August 25, 2021, indicated RN-C met with R1 and encourage him to allow an assessment for his open area. The same note indicated RN-C explained the importance of wound cares and the risk of infection, but the resident refused. The same note indicated the care coordinator was to follow-up on the referral.	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 5 R1's progress notes dated August 30, 2021, indicated the licensee sent R1 to the emergency department after emesis and loose stools. The same document indicated R1 admitted to the hospital. R1's Emergency General Surgery Consult Note dated August 31, 2021, at 12: 43 a.m. indicated R1 had osteomyelitis (an infection of the bone) and a large pressure injury. The same document indicated R1 said his caregivers had been doing some dressing changes to the wound. The same document described the wound as a stage four pressure injury to the sacrum with exposed bone in the wound base accompanied by an image of R1's sacral wound. R1's History and Physical dated August 31, 2021, at 4:22 a.m., indicated R1 admitted to the hospital with diagnoses including sacral pressure ulcer, sepsis (infection of the blood stream), and osteomyelitis. R1's Infection Disease Consult dated August 31, 2021, at 10:37 a.m. indicated R1 had a diagnosis of sepsis with possible "port of entry" as the sacral pressure injury. The same document stated there was imaging concerning for bone involvement and osteomyelitis. R1's Minnesota Documentation of Death indicated R1 died on September 11, 2021. The same document listed the cause of death as including complications of sepsis due to a sacral ulcer. During an interview on November 24, 2021, at 1:00 p.m., ULP-A stated she worked as an "assistant coordinator", and she was not a nurse.	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 6 ULP-A stated R1's skin on his bottom started to breakdown within a week or two after he admitted. ULP-A stated she called MD-G and the clinic to get a home care nurse to see R1. ULP-A stated there was a delay in getting a home care nurse because she did not know it required a referral. ULP-A stated she called and was using dry bandages and an over-the-counter cream recommended by the clinic on R1's sacral wound. ULP-A stated she texted picture to the nurse supervisor, RN-D. ULP-A stated RN-D said she should not have taken on the responsibility of calling people on her own and should have involved RN-D sooner. ULP-A stated the RN-C knew about the wound, but RN-C said she could not just take over but needed something from the clinic. During an interview on November 30, 2021, at 3:36 p.m., RN-D stated ULP-A reached out to MD-G for orders. RN-D stated they did not obtain orders for wound care, but rather a wound care referral. RN-D stated the RN-C attempted to assess R1 but he refused. During an interview on December 1, 2021, at 10:40 a.m., the licensed assisted living director (LALD)-F stated the nurse delegated ULP-A to contact the MD-G to get an order and get R1 to a wound clinic. During an interview on January 6, 2022, at 9:45 a.m., MD-G stated he saw R1 during an appointment on June 22, 2021, which was in-person to address suboxone but there was no concerns raised regarding a wound. MD-G stated the next visit occurred on July 23, 2021, and there was no mention of a wound. MD-G stated the next visit occurred via telephone on August 18, 2021, which was the first time a member of the	01410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
01410	Continued From page 7 staff talked about an open pressure injury, which he could not assess via a telephone visit. MD-G stated he sent a referral for home care wound care, but there was no contact with the licensee after the referral. MD-G stated if the licensee had concerns which not addressed during a visit the licensee would contact him about it. During an interview on March 16, 2022, at 2:10 p.m., RN-E, a nurse employed at the clinic where MD-G worked, stated if the clinic receives a phone call regarding a resident the clinic documents the phone call and forwards the concern to the provider/MD-G. RN-E stated there were phone calls from the licensee regarding R1, but no phone calls concerning a wound. RN-E stated the only referral in R1's record was dated August 18, 2021. A licensee-provided document titled Care Coordinator Job Duties dated October 1, 2018, indicated the role of care coordinator included "liaise" with physicians, social workers, and family alongside administration and nurse management to meet all resident needs. TIME PERIOD FOR CORRECTION: 7 days	01410		
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 interviews and document review, the	02360	No Plan of Correction (PoC) required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING MEADOWS	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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
02360	Continued From page 8 licensee failed to ensure one of one residents/clients reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On April 21, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility/an individual staff person 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.	02360	Please refer to the public maltreatment report (report sent separately) for details of this tag.	