

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL295364861M  
**Compliance #:** HL295366381C

**Date Concluded:** January 13, 2025

**Name, Address, and County of Licensee**

**Investigated:**

Caring Nurses, Inc.  
7723 Brooklyn Boulevard  
Brooklyn Park, MN 55443  
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:**

Katie Germann, RN, Special Investigator

**Finding:** Substantiated, facility responsibility

**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 a resident when the resident developed two pressure sores, one on each his left and right scapula (shoulder bone). The wounds, along with an existing sacral (tailbone) wound continued to deteriorate due to the staff not repositioning the resident as ordered by his provider.

**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 the residents air mattress was functional and the resident was left lying on the bare springs of his metal bed for approximately seven days. The resident developed two new, unstageable, pressure injuries to his right and left scapulas (shoulder bones).

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigator contacted the wound clinic nurse as well as the home care nurse. The investigation included review of hospital records, resident medical chart, home care nursing notes, wound clinic notes, nursing assessments, and facility policies and procedures. The investigator observed staff providing resident cares.

The resident resided in an assisted living facility. The resident's diagnoses included acute traumatic quadriplegia. The resident's service plan included assistance with grooming, dressing, bathing, repositioning, transfers, mobility, meals, housekeeping, and laundry. The resident's assessment indicated the resident was unable to perform body movement independently.

An outside report detailing the incident indicated the resident's pressure injuries on his scapulas and sacrum were deteriorating due to a lack of hygiene and lack of interventions implemented by the facility. The resident appeared to not have been washed and he was not being repositioned as ordered.

Nursing notes indicated the resident's air mattress was not functioning and the resident was lying on bare springs for an undetermined amount of time. The facility nurse contacted the mattress company to come to the facility and replace the mattress. The notes indicated the resident had new open pressure injuries on his right and left scapula after the mattress malfunctioned. The nurse's notes indicated the mattress was replaced seven days after it initially deflated.

Hospital notes indicated the resident had two new unstageable pressure injuries to the right and left scapulas after an air mattress failure at the facility.

During an interview, an unlicensed staff stated when he discovered the resident's air mattress failed, he reported to the facility nurse. The unlicensed personnel stated the staff was directed to get the resident up in his chair and reposition him more when he was in his bed. The bed was flat until the replacement arrived.

In an interview, the wound clinic nurse stated the resident was initially being treated for pressure injuries on his sacrum, left elbow and both feet. On his second visit two weeks later, the resident developed two new unstageable pressure injuries to his scapula. The nurse stated the sacral and scapula pressure injuries worsened overall.

During an interview, the home care nurse stated they provided daily wound care for the resident, and they implement orders given by the wound clinic. The nurse stated she was unsure if the facility was following the recommended repositioning times, however, when she was at the facility the resident would be in a different position at times.

In an interview, the facility nurse stated facility staff were directed to reposition the resident every two hours. The residents pressure injuries were cared for by home care, so nursing did

not have a lot of information. The nurse stated she did not recall any details of when the resident's air mattress deflated, when the mattress was replaced, or how the resident obtained the new unstageable pressure injuries to both scapulas.

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:** Yes

**Family/Responsible Party interviewed:** No, unable.

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:**

No action taken.

**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.

You may also call 651-201-4200 to receive a copy via mail or email.

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 Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>29536</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CARING NURSES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443</b>
--	---

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p><b>#HL295366381C/#HL295364861M</b></p> <p>On December 4, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were seven residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for <b>#HL295366381C/#HL295364861M</b>, tag identification 2360.</p>	0 000		
02360	<p><b>144G.91 Subd. 8 Freedom from maltreatment</b></p> <p>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.</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>29536</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CARING NURSES LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443</b>
--	---

(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	<p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p> <p>No plan of correction is required for this tag.</p>	02360		