Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL298565201M
Compliance #: HL298567020C

Date Concluded: November 4, 2024

Name, Address, and County of Licensee Investigated:
The Homestead at Anoka
3002 4th Ave. 220
Anoka, MN 55303
Anoka County

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

Evaluator's Name:
Katherine Barnhardt 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 the resident when facility licensed staff failed to communicate, assess, document, and implement wound care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility licensed staff failed to communicate with each other about the resident's wounds, failed to process provider orders for wound care, failed to assess the resident's wounds, and failed to provide wound care according to the provider orders.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and an alleged perpetrator. The investigator contacted a home care agency and a family member. The investigation included review of the resident record, rounding provider records, home care records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The

investigator observed facility staff interact with the resident and noted a bandage in place on top of the resident's right hand. The bandage was not dated or initialed.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with activities of daily living, medication reminders and monitoring for fall prevention. The resident's assessment indicated the resident had impaired cognitive abilities, relied on staff for reminders and cueing, utilized a manual wheelchair for mobility, and had a history of falls and skin injuries.

Service completion records included documentation licensed staff changed the resident's bilateral (both sides) forearm wound bandages twice over a period of five weeks, one day a week for the first two weeks of July 2024.

The resident's unsigned July 2024 assessment did not contain identifying information of the licensed staff that completed the assessment and did not include any assessment of skin condition or wounds.

Progress notes indicated the last week of June 2024, a licensed staff contacted the resident's medical provider to request antibiotics (medication to prevent infection) for bilateral forearm skin tears. A progress note dated the first day of August 2024, indicated a licensed nurse was called to the resident's room to observe the resident's bilateral forearm wounds that were macerated (softening and breaking down of skin) with greenish drainage surrounding old bandages. The bandages were not dated or initialed and the last bandage change date was unknown. The licensed staff notified the resident's medical provider of the wounds.

Review of the facility's internal investigation indicated a licensed staff reviewed the resident's record the first week of August 2024. and found unlicensed staff had notified another licensed staff of the resident's bilateral forearm wounds the last week of June 2024. During the investigation, the licensed staff observed bandages on the resident's arms that were not dated or initialed and needed to be changed. The licensed staff found no wound care orders, no record of bandage changes and no progress notes monitoring the wounds for the previous five weeks. Unlicensed personnel failed to enter the resident's forearm wounds in a staff communication log because the unlicensed staff thought licensed staff were aware of the wounds that had been present for "at least 2-3 weeks". The internal investigation also found a note unlicensed staff had posted on the main page of the electronic system notifying licensed staff of the resident's skin tears to both forearms. The licensed staff notified the resident's medical provider of the facility findings and the provider stated verbal orders were given to a licensed staff the end of June 2024. No documentation of verbal orders was found, and no referral orders were forwarded to a home care agency for wound care. Five-weeks later, the medical provider issued a new order to the facility for wound care to be managed by a home care agency.

Home care records indicated the home care agency received orders from the facility to manage the resident's bilateral forearm wounds the first week of August 2024. The records indicated the resident's medical provider had initially ordered the resident's wound care services the last week of June 2024, however, the June 2024 orders had not been forwarded to the home care agency. The records indicated skilled wound care staff did not provide skilled wound care services until the second week of August 2024. The resident's left forearm wound measured eight-centimeters and the right forearm wound measured six-centimeters when the resident was admitted to home care.

Medical provider notes indicated at the end of June 2024; licensed staff requested an antibiotic (medication to prevent infection) for the resident's bilateral forearm skin tears that occurred the prior week. The resident's medical provider visited the resident that day and the antibiotic was ordered along with wound care orders. The medical provider notes indicated orders provided in June 2024, were not implemented and new orders were requested on August 1, 2024. Medical provider notes indicated five weeks had passed from the time the provider initially ordered the resident's wound care until the resident's wound care began.

During an interview, a home care licensed staff stated the resident's wound care services began the second week of August 2024, and included two or three visits a week. The licensed staff stated it was unknown how long the resident had the bilateral arm wounds. The forearm wounds were large with one wound infected. The home care licensed staff stated she had heard there was a period of time and a delay before the medical provider was contacted about the wounds due to licensed staff conflicts at the facility.

During an interview, unlicensed personnel stated she reported the bilateral forearm skin tears to licensed staff and on one occasion observed two licensed staff provide wound care for the resident. The unlicensed personnel stated unlicensed personnel were not trained to provide wound care and when a wound was found the unlicensed staff notified licensed staff.

During an interview, another unlicensed personnel stated all wound concerns were reported to licensed staff. The unlicensed personnel stated she would not know how to tell when a bandage was changed or who to contact if a date and initial were not on the bandage. Unlicensed personnel stated sometimes information about wounds was shared with staff on the front page of the electronic system and sometimes it was not, but the page was viewed by all licensed and unlicensed facility staff.

During an interview, licensed staff stated many licensed staff had started employment but left the facility after a short period of employment leaving a heavy workload for the remaining licensed staff. The licensed staff stated at times she was responsible for residents on all three floors and a memory care unit. The licensed staff stated the resident's wound information was known by all licensed staff because information was posted on the facility's electronic systems front page that was viewed by all staff when they opened the computer and logged on to the system. The licensed staff stated she had updated another licensed staff but was unsure if the

other licensed staff had looked at the wounds or changed bandages. The licensed staff stated she had changed the resident's bandages, however, was unsure if she had signed off on the bandage changes or documented anything in the resident's record. The licensed staff stated she updated the other licensed staff on the resident's wounds but did not recall receiving verbal orders for wound care.

During an interview, the resident stated his wound bandages are changed regularly now and staff provide the resident with his needs.

During an interview, a family member stated family was made aware of the wound incident by the medical provider and an outside agency was given orders to provide wound care going forward for the resident. The family member stated communication with the facility was a challenge during that time and a licensed staff had reached out to the family and stated licensed staff had "dropped the ball".

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation.

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
Anoka County Attorney
Anoka City Attorney
Anoka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29856	A. BUILDING: _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

(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 *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL298565201M/#HL298567020C On October 14, 2024, 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 84 residents receiving services under the assisted living with dementia license. The following correction orders are issued for #HL298565201M/#HL298567020C, tag identification 2310 and 2360.	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.	
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (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 observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, and medical or nursing standards for one of one residents (R1) who required wound care. This failure had the potential to affect all residents with a change of condition and required wound care. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Review of R1's medical record indicated R1's diagnoses included dementia. R1's required staff assistance completing activities of daily living, medication reminders, and monitoring for fall prevention. R1 had impaired cognition, relied on staff for reminders and cueing, used a manual wheelchair for mobility, and had a history of falls and skin injuries. R1's progress notes dated June 27, 2024,	02310		

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02310	Continued From page 2 indicated licensed staff were notified of R1's bilateral forearm wounds by unlicensed staff through an electronic notification system. Licensed staff notified R1's medical provider about R1's bilateral forearm wounds and an antibiotic (medication to prevent infection) was requested. Medical provider notes dated June 27, 2024, indicated R1's medical provider issued orders to the licensee for Keflex (antibiotic medication for infection) to be administered three times daily for seven days for a wound infection and home care nursing orders to evaluate and treat R1's bilateral arm wounds. The facility licensed staff did not process the orders and R1 went without wound care management. A progress note dated July 15, 2024, indicated licensed staff and R1's family met for a family conference. Notes from the family conference did not include discussion of R1's wounds. A progress note dated August 1, 2024, indicated unlicensed personnel (ULP) called a licensed staff to R1's room to observe R1's arm bandages condition. The progress note described the wounds as " left measures 8 centimeters (cm) round with red wound bed with some surrounding macerated (softening and breaking down) skin and old dry greenish drainage on old non-adherent pad. The right wound measured 5 cm by 3 cm with a red wound bed and scant old greenish dry drainage on old Band-Aid. Medical provider notes dated August 1, 2024, indicated RN-G updated R1's medical provider that the initial orders for R1's wound care from June 27, 2024, had not been processed and completed. The medical provider gave wound	02310		

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02310	Continued From page 3 care orders a second time, five weeks after the initial orders. Review of the licensee's internal investigation dated August 1, 2024, indicated on June 20, 2024, a ULP notified licensed staff of R1's wounds. On June 27, 2024, licensed staff notified a medical provider of R1's wounds and requested antibiotics. There was no further documentation of R1's wound or wound care between June 27, 2024, and August 1, 2024. When licensed staff observed R1's bandages on August 1, 2024, the bandages were not dated or initialed and the last bandage change was unknown. RN-G contacted R1's medical provider and requested wound care orders. The wounds were unmanaged by licensed staff for a five week period from June 27, 2024 to August 1, 2024. On October 14, 2024, at 11:52 a.m., the investigator observed R1 sitting at a dining room table with a 4"x 4" bandage on the top of his right hand. The bandage was not dated or initialed. On October 14, 2024, at 12:36 p.m., the investigator observed unlicensed personnel (ULP)-B push R1 back to his room in a manual wheelchair. On October 14, 2024, at 1:12 p.m., ULP-B verified R1's bandage was not initialed or dated and stated ULP's would not have a way of knowing when R1's bandages were last changed. On October 16, 2024, at 9:40 a.m., RN-G stated at the end of June 2024, two RN's and one licensed practical nurse (LPN) were employed at the facility. RN-G stated a LPN was responsible for the third floor of the building. RN-G stated she was unaware R1 had wounds until a ULP called	02310		

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02310	Continued From page 4 her to R1's room on August 1, 2024. RN-G stated her role was to oversee nurses, staff and coordinate care between residents and physicians. RN-G stated it was the responsibility of a RN to assess for changes in condition and delegate treatment tasks. R1's record lacked evidence the registered nurse (RN) completed an assessment/reassessment following notification of R1's arm wounds on June 27, 2024 The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated March 2018 indicated a delegation occurs when the RN transfers the responsibility for the performance of a nursing task in a specific situation to another nursing staff member who is competent to perform the task, while the RN retains the accountability for the outcome. The licensee's Initial and On-Going Nursing Assessment policy dated March 2018 indicated the RN would review the nursing assessment and service plan /care plan whenever the resident has a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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.	02360		

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02360	Continued From page 5 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. Findings include: 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.	02360	No plan of correction required.	