

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303454263M
Compliance #: HL303457216C

Date Concluded: November 22, 2023

Name, Address, and County of Licensee

Investigated:

Golden Horizons Assisted Living
1790 College Way
Worthington, MN, 56187
Nobles County

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

Evaluator's Name: Christine Bluhm, 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:

The facility neglected the resident when the facility did not complete wound care and the resident's wound became infected.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility completed dressing changes for the resident's wound. Although the dressing changes may have not been done consistently and the wound worsened, the bone did not become infected. Other factors may have contributed to the wounds progress.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of facility policies and records of residents who received wound care services. Also, the investigator observed staff providing direct resident care.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes with neuropathy (loss of feeling in lower extremity) and a chronic heel ulcer. The resident's service plan included assistance with medication management, glucose monitoring, wound care, bathing, housekeeping, and laundry.

The resident's assessment indicated the resident had a chronic heel ulcer that required dressing changes under the guidance of the wound clinic. The resident had progressive weakness and was unable to stand without bearing weight on her heels. The resident required staff reminders to not self-propel in the wheelchair as this would put pressure on the heels and to keep feet elevated while in the recliner.

The progress notes indicated the resident was seen in the wound clinic weekly for wound care.

The investigation included a review of wound clinic notes spanning more than one year. The notes indicated that over this period the wound improved and worsened again multiple times. Over that time, the resident reported that wound dressings were not applied correctly or consistently. The provider's notes indicate the wound clinic followed up with the facility when the resident raised concerns about wound care. The same documents indicated the resident reported she at times propelled herself using her feet in the wheelchair and the wound clinic encouraged her to not do so.

The resident's service delivery records indicated wound dressing changes were scheduled every morning. The records indicated the changes were signed off as completed but sometimes it was signed off as completed later in the day.

During an interview, an unlicensed caregiver stated the dressing changes were to be done daily although the resident would want to wait until after her shower to change it so the wound care was at times delayed.

During interview, a facility nurse stated the resident's wound was assessed weekly on her bath days and there may have been signs of cellulitis but not specifically infection.

During an interview, another nurse stated the resident did not always alert staff when the dressing fell off or needed to be replaced.

During interview, the wound clinic provider stated the resident's wound worsened but not to the point of infection.

During an interview, the resident stated her doctor was concerned about the wound not being redressed daily. She stated the dressing changes sometimes did not get done in the morning and when the next shift staff came in, they did not want to change the dressings. Other than that, it was a good place to live.

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: No.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

No action taken.

Action taken by the Minnesota Department of Health:

No action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30345	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2023
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NAME OF PROVIDER OR SUPPLIER GOLDEN HORIZONS OF WORTHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1790 COLLEGEWAY WORTHINGTON, MN 56187
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(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>On August 9, 2023, through August 10, 2023, the Minnesota Department of Health initiated an investigation of the following complaints: HL303454263M/HL303457216C and HL303457325M/HL303453872C.</p> <p>No correction orders are issued.</p>	0 000		

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