Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303457325M
Compliance #: HL303453872C

Date Concluded: December 7, 2023

Name, Address, and County of Licensee Investigated:
Golden Horizon 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: Inconclusive

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 failed to monitor and assess the resident for pressure sores. The resident was found to have an unstageable pressure wound with a foul odor upon transfer to another facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility documented the resident's refusals of repositioning, incontinence care, bathing and he had a sore and reddened coccyx. After the resident was transferred to a skilled nursing facility and concerns were raised that the resident had a more advanced wound than what the facility reported, the facility provided detailed wound tracking records and handwritten edits to the previous assessments. However, details regarding the care of the wound and the wound itself was not evident during staff interviews. Staff members did indicate that assessing the wound was difficult because of the resident's refusal to lay down in bed for care. The ALF's description

of the wound is not consistent with the SNF's description or photos of the wound on the same day but the situation was complicated the resident's refusal of cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical records, as well as other records of residents with pressure wounds at the facility. Facility incidents, recent hospitalizations and policies were reviewed.

The resident resided in an assisted living facility (ALF). The resident's diagnoses included multiple sclerosis (MS) and neurogenic bladder (the inability to control the bladder). The resident's service plan included assistance with all activities of daily living which included mobility and transfer assistance. The resident's assessment indicated he was oriented and could make his needs known.

When the resident transferred from the ALF and admitted to a skilled nursing facility (SNF), he e had bottom area of pain for at least two weeks that was bad enough he was not able to sit on his bottom and had to lean to the side to offset the pain.

Review of the SNF nursing assessment records indicated that upon admission, the resident had a 2 centimeter (cm) by 2 cm open area which appeared to be tunneling. Review of the admission wound photos clearly showed a wound which is open with tunneling.

The resident's ALF record indicated staff members documented the resident's refusals with toileting, incontinence, and hygiene care in the months prior to the resident's discharge. The records did not indicate if any pressure relieving devices or interventions were in place, but indicated the risks of the refusals were discussed repeatedly with the resident.

The resident's ALF wound care tracking record indicated the wound was dressed daily and assessed weekly, yet the resident refused to lay in bed. On the day of the transfer to the SNF, the ALF nurse documented the wound to be red and slightly bleeding.

During an interview, an unlicensed ALF caregiver stated the resident would frequently refuse incontinence care, repositioning in his chair and lay in bed.

During interview, the ALF nurse stated the resident became weaker and could not offset his weight on his own. The nurse stated the resident slept in the recliner chair and refused to lay in bed. The resident refused incontinence care and with concern for skin breakdown, it was advised that a Foley catheter be placed, but the resident declined the option and standing orders for wound care were followed for the resident. The nurse stated assessments were done while the resident was toileted except for one time they were able to lay him down in bed. The nurse stated the sore had slight bleeding and was not open the day he discharged from the ALF.

During interview, a nurse from the SNF, stated they were told the resident had a sore on his bottom that was not open. When the resident admitted, the wound was a stage four tunneling wound on his sacral area. The nurse stated that the ALF did not provide any wound care documentation or communication about an advanced pressure wound.

During interview, a family member stated she was not made aware of the resident's risk of pressure sore wounds or that the resident had a sore on bottom that was forming.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken. The resident transferred to a higher level of care at the SNF.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS OF WORTHINGTON	1790 COLLEGEWAY WORTHINGTON, MN 56187

(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 August 9, 2023, through August 10, 2023, the Minnesota Department of Health initiated an investigation of the following complaints: HL303454263M/HL303457216C and HL303457325M/HL303453872C. No correction orders are issued.	0 000		