Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30745009M
Compliance #: HL30745010C

Date Concluded: April 25, 2022

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Pkwy
Lino Lakes, MN 55104
Anoka County

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

Evaluator's Name: Yolanda Dawson, 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 did not provide the resident with adequate continence and repositioning assistance, resulting in inadequate wound healing.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide essential incontinence and repositioning care, the resident was repeatedly found saturated in urine, and this contributed to deterioration of the resident's wound.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff, as well as agency wound care nurses. The investigator reviewed resident records from facility and nursing agency, employee files, incident reports, and facility policy and procedures.

The resident's medical diagnoses included a tailbone pressure ulcer, backpain, osteoarthritis, diabetes type II, chronic heart failure, obesity, and peripheral vascular disease and stage 3

kidney disease. The resident received services for continence care, positioning and transfer assistance.

The resident's wound care notes indicated the resident had a pressure ulcer located on her tailbone and instructions for direct care staff to offload, reposition and provide continence care every two hours to redistribute pressure points and to keep skin dry. This document also showed a wound care nurse found the resident's incontinence product saturated on four days and documented wound deterioration seven times throughout the same period.

The resident's flowsheet for positioning and continence care showed forty times when there was no documentation of whether the service was provided. It also showed thirty times the direct care staff members documented they had provided the scheduled services all at one time; for example, on multiple dates, the direct care staff documented three or four entries of providing the continence assistance scheduled for every two hours, all at the same time, at a time around the beginning of the shift.

During an interview, wound care nurse #1 stated a direct care staff member admitted to her and a facility nurse that she was not checking for incontinence or changing the resident, however, she was turning the resident every two hours. Nurse #1 stated it did not matter what time of the day she arrived, she would always find the resident saturated with urine. Nurse #1 stated that during the month that she provided the resident with wound care services, the wound became bigger and deeper. Nurse #1 stated she talked to staff and management on several occasions to stress the importance of repositioning and continence care.

During an interview, wound care nurse #2 stated the resident's wound was pressure and moisture related. Nurse #2 stated a pressure injury can decline within hours without proper repositioning and moisture prevention. Nurse #2 stated the wound care nurses taught direct care staff and managers on several occasions the importance of keeping the resident dry and turning her every two hours to promote healing and prevent wound breakdown. Nurse #2 stated wound measurements showed the pressure ulcer was getting larger and photos showed the wound had skin loss related to prolonged moisture.

During an interview, an unlicensed direct care staff member stated staff members were not turning and changing the resident every two hours. The unlicensed personnel (ULP) stated the night shift would not turn or change the resident, and when she started her shift in the morning, she would find the resident saturated with urine. The ULP stated because of this the resident's wound became infected and started to tunnel. The ULP stated she reported this to management, and management did not respond.

During an interview, a nurse and a director acknowledged that direct care staff documentation on the resident's flowsheet was erroneous and incomplete.

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:
One employee is no longer employed by the facility. Staff were reeducated on resident responsibilities and on documentation requirements.

Action taken by the Minnesota Department of Health:
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
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING LLC	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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: #HL30745010C/#HL30745009M On March 8, 2022, 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 100 resdients receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL30745010C/#HL30745009M, tag identification 2360.	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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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 facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On April 25, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility 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	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	