Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307624264M
Compliance# HL307627219C

Date Concluded: December 29, 2023

Name, Address, and County of Facility Investigated:
The Wellstead of Rogers
20600 South Diamond Lake Road
Rogers, MN 55374
Hennepin County

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

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Not Substantiated

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): The facility neglected the resident when the resident developed a wound on his left foot and staff failed to provide ongoing assessments and wound care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident developed tissue damage to both feet, which progressed over a period of months due to an existing medical condition. The facility staff and the hospice provider worked together to monitor and continually assess for further injury.

The investigator conducted interviews with facility nursing staff and the resident's family. The investigation included review of the resident's medical record, facility staffing schedules, personnel files, policies, and grievances. At the time of the onsite visit the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included congestive heart failure, acute respiratory failure, and Dementia. The resident's service plan directed staff to provide assistance with medication administration, activities of daily living, housekeeping, and meals. The resident's nursing assessment completed months prior to his decline in health, indicated the resident was able to use a four-wheeled walker and was able to transfer with minimal assistance but may need cueing or reminders. The assessment was later updated to include the resident's need for assistance of two caregivers and the use of a mechanical lift. The resident also received hospice services and wound care and monitoring services from an outside agency.

Complaint documents indicated that on one occasion when reviewing the resident's medical record, the record lacked documentation specific to the care of the left foot condition. When questioned about the care surrounding the resident's feet, facility staff were unable to clearly explain what was being done to care for the resident's left foot.

Review of the hospice provider's progress notes indicated that wound care began on the right foot five months prior to the filing of the complaint. It was also noted that ongoing assessments of the left foot, due to a change in condition, began two weeks later. At the time it was first mentioned, no wounds had appeared on the left foot. The nurse practitioner assessed the left foot and noted this as a complication of a disease process.

Review of the facility progress notes indicated that facility nursing staff had documented an area described as a necrotic (tissue destruction) measuring 1.7 centimeters (cm) x 2 cm on the resident's third toe of the left foot, six weeks prior to the complaint being filed. The note detailed the area to be clean with a small amount of sanguineous discharge (a clear fluid) on the right edge of the area, and dryness between the toes of the foot with flaky dryness that ran up the top of the foot. The heel was reddened, dry and flaky.

During an interview with a facility nurse, she stated that at this time the resident was also being monitored by the hospice agency. The hospice agency provided feedback, collaboration, and a wound care plan. The unlicensed personnel at the time were directed to provide complimentary wound specific cares only, which included positioning of the extremities and the use of pressure relieving devices.

During an interview with the resident's family member, they stated they were notified frequently of any changes to the resident's condition including the progression and treatment of all wounds. The family confirmed the resident was born with a congenital condition affecting circulation of the left lower extremity. They had no other concerns surrounding this incident or the care provided by the facility.

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: No. (Deceased)
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A.

Action taken by facility:
The facility staff continually assessed the resident’s condition in collaboration with the hospice provider. Additional training was offered to facility staff.

Action taken by the Minnesota Department of Health:
No further 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
	30762	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSTEAD OF ROGERS	20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374

(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 November 6, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307627219C/#HL307624264M. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	