Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312206824M
Compliance #: HL312201392C

Date Concluded: March 20, 2025

Name, Address, and County of Licensee Investigated:
Peaceful Living LLC
1687 Fallbrooke Drive
Hastings, MN 55033
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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(s):
The facility neglected the resident when the resident had a wound of unknown origin on her right shoulder that caused pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident developed a wound, it is unable to be determined if the action or inaction of facility staff was the direct cause of the worsening of the resident's wound.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the physician. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included autism spectrum disorder, anxiety, and obsessive-compulsive disorder. The resident's service plan included assistance with medication administration and observation for skin concerns. The resident's assessment indicated the resident was moderately cognitive impaired and was easily influenced by others.

Documentation indicated skin on the resident's right shoulder was slightly raised, red, and warm to the touch. Instructions were given by the facility nurse to apply a warm pack to the area and administer pain medication two times a day until healed. The facility nurse advised staff that if the area worsened or increased, the resident would need to see a doctor.

The next day, staff noted the area had turned into two blisters and one had opened. A staff member cleansed the wound and put ointment and a dressing on per a family member's request.

The resident's medical record lacked evidence the facility had orders for an ointment to be applied.

Two days later, staff noted that the resident was picking at an open area on her right shoulder. A photo was sent to the facility nurse. Staff reported the resident did not know what happened and reported she hurt herself at work. Staff reported that the resident's family member was aware and had purchased ointment and had asked staff to apply it a couple times a day. The facility nurse gave instructions to fill out an incident report, apply ointment, and cover the area.

The resident's medical record lacked evidence that the facility nurse directly assessed the wound.

Three days later, hospital records indicated the resident was seen for a rash on her right shoulder that had been present for one week. Facility staff applied heat and had a bandage on her shoulder which caused further skin breakdown. Hospital records indicated concern for burn or friction abrasion. The resident was discharged back to the facility with orders to use Vaseline (a type of petroleum jelly used as an ointment and lubricant) with no application of additional ointments to the area.

During an interview, a staff member stated she saw the red spot and reported it to the facility nurse who gave her instructions to put heat on the red mark, and give as-needed pain medication. A staff member put a warm washcloth in a plastic bag and applied it to the resident's red mark on her shoulder.

During an interview, the facility nurse stated when she saw a picture of the red mark she was not concerned; however, she advised a staff member to apply heat by putting a washcloth under warm water, place it in a plastic bag, and place a washcloth between the resident's skin and the plastic bag for 15 minutes. The facility nurse stated staff did not report to her that the

red mark worsened and blistered. When the facility nurse was updated by facility management, she advised staff to apply ointment and a bandage. The facility nurse stated she did not see the wound until after the resident went to the hospital.

During an interview, the resident stated the red mark was originally caused from her bra and that staff applied a hot pack to the area that burned her. The resident stated after the hot pack, the staff applied medicine until it healed.

During an interview, a family member stated she was told a staff member put a hot pack on the resident's shoulder for 20 minutes when a red spot was noted. The red spot blistered and got worse. A family member applied an ointment and advised the facility staff to apply it. A family member stated the wound got worse and she decided to bring the resident to the hospital. After the resident was seen by a medical provider and the orders were changed to Vaseline, the wound improved immediately. A family member stated there have been no concerns since and feels nobody intentionally hurt the resident.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed education to staff after the incident occurred.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31220	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LIVING LLC	1687 FALLBROOKE DRIVE HASTINGS, MN 55033

(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 PROVIDER 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: #HL312201392C/#HL312206824M On February 26, 2025, 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 7 residents receiving services under the provider ' s Assisted Living license. The following correction order is issued/orders are issued for ##HL312201392C/#HL312206824M, tag identification 2320.	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.	

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02320	Continued From page 1	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide appropriate health care services from people who were properly trained and competent when there was no system in place to ensure appropriate assessment, monitoring, and treatment were provided by facility staff. Facility nursing staff failed to assess an area of skin concern and failed to update the medical provider regarding progression of a wound for one of one (R1) resident reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included autism spectrum disorder (ASD), anxiety, and obsessive-compulsive disorder.	02320		

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02320	Continued From page 2 R1's care plan dated June 1, 2024, indicated R1 received assistance with toileting, medication administration, and observation for skin concerns. R1's progress notes dated October 26, 2024, at 8:44 a.m., indicated R1's skin on her right shoulder was the size of a baseball that was slightly raised, red, and warm to touch. Instructions given by registered nurse (RN)-B was to administer a warm pack on the area and to administer Tylenol per as needed (PRN) order two times a day until better. If the area had spread, R1 would need to see a doctor. R1's progress notes dated October 27, 2024, at 6:28 a.m., indicated R1 had two blisters, one burst open and the other was the size of a pencil eraser head. R1's progress notes lacked evidence a nurse or medical provider was updated regarding the change in skin condition. R1's progress notes dated October 27, 2024, at 9:24 p.m., indicated staff cleansed the wound on R1's right shoulder, put ointment and a dressing on the area per family member (FM)-C's request. R1's progress notes dated October 29, 2024, at 6:59 p.m., indicated R1 was picking at her right shoulder. Facility management discovered an additional open area of the right shoulder having skin irritation that looked dark brown/wrinkled. A photo was sent to RN-B. Staff reported R1 did not know what happened and reported R1 hurt herself at work. Staff reported FM-C was aware and had purchased bacitracin (a polypeptide antibiotic used to treat bacterial skin infections or to prevent infection of minor burns, cuts, or scrapes) and advised to apply the ointment a couple times a day. RN-B gave instruction to fill out incident report, apply bacitracin, and cover the	02320		

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02320	Continued From page 3 area. R1's medical provider was not updated on the change in skin condition and no physician orders were obtained for the treatment to the area. R1's incident report dated October 29, 2024, at 6:59 p.m., indicated staff alerted facility management of R1's skin injury. R1 stated she burned herself at work. FM-C bought bacitracin, but nothing had been reported RN-B or facility management. R1's progress notes dated October 29, 2024, at 7:00 p.m., indicated R1's wound was redressed. Instructions given by RN-B indicated to clean with soap and water and dry completely. Apply a "good amount" of bacitracin to the gauze to prevent sticking and apply gauze to wound or if the facility had a bandage large enough then that could be used. R1's progress notes dated October 31, 2024, at 8:56 p.m., indicated FM-C would be bringing R1 to the hospital on November 1, 2024, for the burn on her shoulder. R1's standing orders dated August 25, 2023, indicated for skin, apply A & D ointment PRN to dry, reddened, or rash areas. For minor cuts and abrasions clean with soap and water. Apply bacitracin (first aid cream) and dressing as necessary. The facility lacked evidence the prescriptions for the standing orders were current at the time of the incident. R1's medication administration record (MAR) dated October 2024 indicated the A & D ointment (daily), clean area well with soap and water. Dry. Apply ointment as needed to dry, reddened or rash areas. Call RN if wound is open or bleeding	02320		

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02320	Continued From page 4 or no improvements in 48 hours. R1's medication administration record (MAR) lacked evidence A & D ointment was administered. R1's MAR indicated Bacitracin (daily) clean area with soap and water. Apply bacitracin and dressing as necessary. May use steri strips or transparent dressing PRN. Call RN if wound is open, bleeding or has not improved in 48 hours. R1's MAR indicated bacitracin was administered on October 28, 2024. Email communication from facility management to FM-C dated October 31, 2024, at 9:12 p.m. indicated facility management did not know R1 had been hurt at work. Facility management indicated R1's shoulder "did not look so good" and R1 was picking at the area. R1's hospital records dated November 1, 2024, indicated R1 was seen for a rash on her right shoulder that had been present for one week. R1 had reported the shoulder concern to facility staff and RN-B recommended heat. R1 had heat and a bandage on her shoulder which caused further skin breakdown. R1's hospital records indicated the area of concern was due to burn or friction abrasion. R1 was discharged back to the facility with orders to use Vaseline, no additional ointments to be applied, on gauze to keep the wound moist. Orders indicated to avoid the bandage R1 was using. Email communication from FM-C to facility management dated November 1, 2024, at 11:03 a.m. indicated R1 did not obtain her injury at work. Unlicensed personnel (ULP)-A reported to FM-C that R1 woke up October 26, 2024, with a large, red, raised spot on her shoulder roughly the size of a baseball and it was warm to the touch. ULP-A reported it to RN-B. RN-B told ULP-A to	02320		

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02320	Continued From page 5 give R1 two Tylenol and "hot pack it for 20 minutes." R1 told FM-C she had to sit in her bathroom for 20 minutes with the hot pack on her shoulder. ULP-A told FM-C "the hot pack was hot water that she had put in a baggie." There was no evidence of facility follow-up or investigation into the email concern from FM-C to facility management about what ULP-A reported as the initial injury and hot pack treatment to the area. R1's assessment dated November 3, 2024, indicated R1's wound was approximately 3 inches by 3 inches. Open area in the center was healing, no signs or symptoms of infection. Wound was wet but had been covered with Vaseline and nonstick gauze. During an interview February 27, 2025, at 9:10 a.m., ULP-A stated R1 woke up on October 26, 2024, with a red mark on her shoulder. ULP-A put a warm washcloth in a bag and applied it to R1's shoulder. ULP-A stated she was not trained how to make a heat pack. ULP-A stated FM-C picked R1 up that morning and ULP-A reported the red mark to FM-C. During an interview on February 27, 2025, at 9:30 a.m., RN-B stated she looked at the photo sent to her from ULP-A. RN-B stated she didn't notice anything unusual, it looked like a small area of redness. RN-B stated she advised ULP-A to put a warm washcloth in a plastic bag and to apply it on R1 for 15 minutes. RN-B stated she told ULP-A not to use the microwave. RN-B stated she did not assess the wound or lay eyes on the wound but was sent a picture days later from facility management. RN-A stated she was surprised staff didn't report the change sooner because	02320		

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02320	Continued From page 6 when she saw the picture it was blistered and peeling. RN-B did not assess the wound until a couple days after R1 went to the hospital. During an interview on February 27, 2025, at 11:31 a.m. FM-C stated when she picked up R1 on October 26, 2024, there was a large spot that was red and looked tender. As the day went on, the area started to blister. FM-C stated she put Neosporin (an antibiotic medication used to reduce the risk of infections following minor skin injuries.) on R1's shoulder. FM-C stated she did not hear anything from the facility until she picked R1 up on October 31, 2024, and when R1 was picked up, her shoulder looked "horrible." FM-C stated she decided to bring R1 to the hospital because her shoulder was getting worse. During an interview on February 27, 2025, at 3:00 p.m., physician's assistant (PA)-D stated R1's shoulder looked like a burn. PA-D stated bacitracin was fine to apply, but Neosporin would not have been recommended and probably made the wound worse. PA-D stated there was no records the facility reached out to report the initial change in condition in R1's skin or updates as the area worsened. Via an email on March 3, 2025, at 3:52 p.m., director of nursing (DON)-E indicated the expectations and procedures regarding skin concerns reported by the resident included: assessment of skin concerns, MD notification and follow-up, and guardian notification. The licensee's Medications & Treatments policy dated August 1, 2021, indicated Only properly trained staff of the licensee may provide medication assistance or administration. Unlicensed personnel must be trained, and	02320		

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02320	Continued From page 7 competency tested by a RN, with documentation on file. Topical ointment and cream medications must be applied according to the prescriber orders. Cold or Hot packs must be applied following a healthcare provider's recommendation. Packs should always be covered with a protective barrier (eg. towel) to prevent direct skin contact. The application duration should follow the recommended time frame to avoid skin damage. Patients' skin integrity must be monitored before, during and after application. Any adverse reactions (e.g. Burns, excessive redness, numbness) should be reported immediately. The licensee's Resident change in condition or need policy dated August 1, 2021, indicated when changes in condition or need are identified, a Registered Nurse will initiate a change in condition assessment. The assessment may be limited to only those issues where a change has been identified. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		