Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315574422M
Compliance #: HL315578675C

Date Concluded: August 4, 2025

Name, Address, and County of Licensee Investigated:
Farmstead Care of Moorhead
3200 28th Street S
Moorhead, MN 56560
Clay County

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

Evaluator's Name:
Katherine Barnhardt 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(s):
The alleged perpetrator (AP), licensed facility staff, neglected the resident when the AP failed to conduct wound assessments and provide wound care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP monitored and assessed the resident's wounds, coordinated with a wound care provider, requested antibiotics, changed dressings and sent the resident to the hospital for advanced wound care when the wound condition worsened.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a home care agency and a family member. The investigation included review of the resident record, hospital records, pharmacy records, home care records, facility internal investigation, facility incident reports, personnel

files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff interact with residents.

The resident resided in an assisted living with memory care facility. The resident's diagnoses included muscular dystrophy (muscle wasting disease), osteoarthritis of knee (degenerative knee joint) and Charcot-Marie-Tooth disease (neurological disorder affects nerves that connect brain and spinal cord transmission). The resident's service plan included assistance with ambulation, transfers, repositioning, skin and wound care. The resident's assessment indicated the resident required assistance of one for most activities of daily living, assistance of two for mechanical lift transfers and preferred to sleep in his recliner. The resident had a history of venous leg ulcers (slow healing sores caused by weak blood circulation), edema (accumulation of fluid in the body's tissues), and memory impairment.

The resident's record indicated the resident had hardware placed into his right leg in January 2025 and had a history of chronic reoccurring wounds. The resident used utensils to pick and scrape at his skin and wounds causing the wounds to worsen. Unlicensed and licensed staff monitored and assisted with wound care dressing changes. Unlicensed staff notified the AP when changes were observed with the resident's right leg wound and the AP conducted assessments, updated primary care providers and completed dressing changes as ordered. The AP coordinated with a home care agency for wound care services and started the resident on antibiotics when ordered.

Home care records indicated the resident was admitted for wound care services and dressing changes were coordinated between facility and home care staff three days a week and as needed. The resident's dressing changes were to align with the resident's showers three times a week. Licensed home care staff were directed to transition visits to once a week as the resident's wound healed.

During an interview, unlicensed personnel stated the resident's wounds were usually on his legs due to bumping into things and the resident would pick at his skin with utensils making sores worse. Unlicensed personnel stated the resident's wound care was completed on a schedule and as needed dependent on wound care assessments.

During an interview, a licensed home care staff stated the resident's wounds opened and closed, water blisters developed and popped, and abrasions from bumping into things would all turn into wounds. Licensed home care staff stated the most recent wound care orders were for dressing changes three times a week and as needed coordinated with the resident's shower days. Licensed home care staff stated facility licensed staff managed the resident's wounds when home care transitioned to weekly visits. Licensed home care staff stated one week prior to the resident's emergency room visit she observed swelling and redness at an old surgical site on the resident's leg. Licensed home care staff stated the same wound was observed one week later with facility licensed staff and the surgically placed hardware could be seen. Licensed

home care staff stated the AP, herself, and the family agreed the wound was worsening and the resident was sent to the emergency room.

During an interview, the AP stated the resident had chronic wounds from bumping into things when in his wheelchair and was non-compliant with recommendations to prevent wounds. The AP stated the resident's leg wound had gotten significantly worse over a week, photos of the wounds were sent to the resident's primary provider when the wound started to worsen, and antibiotics were ordered. The AP stated antibiotics were started the same day the provider reviewed the photos, and a plan was coordinated for a home care wound nurse to see the resident on the next scheduled day. The AP stated the next step of care was to be determined based on the information gathered during the next coordinated wound care visit with home care. The AP stated she and a licensed home care staff observed the wounds on the scheduled day and agreed to send the resident to the emergency room based on the joint assessment. The AP stated the resident's body was rejecting hardware that was placed into the resident's leg.

During an interview, a family member stated the AP was "very good" at keeping the family updated. A family member stated the resident tended to get infections, was safe at the facility and the family had "absolutely no problem" with the care provided by the AP.

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.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Facility licensed staff collaborated with a wound care service and the resident was sent to the emergency room when the wound deteriorated.

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
	31557	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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 July 24, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL315574422M/ #HL315578675C. 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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	