

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326816946M
Compliance #: HL326811492C

Date Concluded: February 3, 2025

Name, Address, and County of Licensee

Investigated:

River Oaks at Shady Ridge
225 Shady Ridge Road NW
Hutchinson, MN 55350
McLeod County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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 facility neglected the resident when the resident's foot turned purple, did not receive adequate care, and was eventually amputated.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect not substantiated. While it was true the resident did eventually have a left below the knee amputation, the resident had several complicating health concerns including peripheral artery disease (poor circulation). The facility took appropriate steps to address her wounds when they occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety disorder, diabetic neuropathy, arterial disease and chronic left foot ulcerations. The resident's care plan required assistance from two caregivers for all transfers using a Hoyer lift in and out of bed. The care plan indicated the resident was at high risk for skin impairment due to her diabetes, history of stroke which made her left side is partially paralyzed, and lack of sensation in her feet. The care plan indicated the resident was at high risk for skin impairment due to her diabetes, history of stroke which made her left side is partially paralyzed, and lack of sensation in her feet. The care plan also indicated that while she wore shoes, swelling and obesity often made them ill-fitting, and she refused alternatives such as diabetic shoes or loose slippers.

A concern arose the resident's foot was not being adequately treated as it would at times turn purple. Later a wound developed on her foot and the facility sought treatment at a wound clinic. However, eventually the resident required below the knee amputation of the left leg.

The resident's medical record she had multiple wounds and poor circulation in her legs and feet.

Three months prior to the resident's left below amputation, the medical record indicated she had a wound on her *right* little toe which was successfully healed.

Two months prior to the resident's left the facility identified and assessed a skin tear on the back of the resident's knee. The medical records showed the wound was cleansed and dressed. A couple of weeks later, a follow-up assessment indicated the wound behind the left knee was scabbed over.

About a month prior to the resident's left below the knee amputation, the facilities wound assessment indicated the resident developed a stage 1 pressure wound over the left pinky toe. The facility imitated treatment, and a wound care clinic contacted for further follow-up. However, due to the clinic being fully booked, the resident was not seen until a week later. In the meantime, the nurse ordered wounds care, including cleansing the wound, applying antibacterial ointment, covering it with a non-stick dressing, and securing it with Kerlix. The resident was also added to the clinic's cancellation list for an earlier appointment if one became available.

About ten days later and about three weeks prior to the resident's left below the knee amputation, the resident was seen in the wound clinic. The clinic performed debridement on both wounds. Treatment orders included cleansing the left lateral foot wound with normal saline three times per week and applying Aquacel dressing, while the back of the knee wound required cleansing twice daily with normal. The wound clinic records indicated the resident had a history of previous left toe amputations including the left great toe and the 2nd toe from the previous spring.

Meanwhile, the facility set up weekly wound assessment for the resident. The care plan also indicated wound assessments were performed weekly by the nurse.

The following week and two weeks prior to her below the knee amputation, the facility progress notes indicated the resident was seen by a podiatrist regarding her wounds.

Approximately ten days prior to the residents below the knee amputation the wound clinic notes indicated she was seen again. The same document indicated she had a new wound to her the front of her left knee due to trauma as the resident had accidentally hit her knee while using her wheelchair into a door. This new wound was addressed along with her previous left leg wounds.

About a week later the resident was sent to the emergency room (ER) and admitted to the hospital during which her left below the knee amputation occurred. The ER records indicated the resident had a history of diabetes, peripheral arterial disease with chronic left foot ulcerations, and had developed an infection in the left foot wound. The same document indicated the resident's "significant vascular disease" increased the difficulty of revascularization and was at risk for poor wound healing. The recommendation included transfer to a different hospital to consider surgical options. The resident was transferred to a different hospital and underwent a left below the knee amputation.

During an interview, unlicensed caregiver #1 stated she had observed the resident foot turn purple and was concerned about the care she received and if it was too late. She could not recall exactly when she first noticed the wound on the resident's foot but estimated it may have been in 3-5 months before the resident underwent her left below the knee amputation.

During an interview, unlicensed caregiver #2 stated that the resident initially had a wound on her toe and sustained a wound on her knee after hitting it against a wall, which became infected. Caregiver #2 stated she felt the nurses did not consistently or properly clean and wrap the wounds but also at times the resident refused treatment. Unlicensed caregiver #2 further stated the resident had the wound on her toe for several months, during which time she lacked insurance. Consequently, she was unable to visit the wound clinic, and the facility provided wound care onsite. However, when the resident had insurance, she attended the wound clinic three times a week for treatment.

According to the hospital records, the resident had been receiving care at a wound clinic in the past for a wound located on the *right* lateral fifth [little] toe for over a year. Those same records indicated the cares provided by the wound clinic were at times interrupted due to lack of insurance coverage due to lack of necessary information regarding the resident [the wound that had healed three months prior].

During an interview, the manager, who was also a nurse, stated the resident developed a wound on her toe toward the end of her stay at the facility. She said the unlicensed caregivers

were instructed to notify the nurse of any open sores observed during the resident's showers plus the nurse also conducted weekly skin/wound assessments for the resident due to her high risk of skin impairment. The manager said she performed wound care for the resident while the resident awaited her wound clinic appointments and/or followed the clinic's orders for wound care. The manager that when the wound on the resident's left toe was found at the end of an appointment was scheduled with the wound clinic as soon as possible [which was consistent with contemporaneous documentation]. The manager said the resident was eventually admitted to the hospital, where she underwent a left leg amputation, and went to a different facility afterwards.

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, attempts unsuccessful

Family/Responsible Party interviewed: Not applicable

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility conducted weekly wound assessments, provided wound care, and implemented appropriate interventions. The facility coordinated cares with a wound clinic, provided cares when the resident did not have insurance for the wound clinic, and sought emergency room evaluation appropriately.

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32681	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2025
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NAME OF PROVIDER OR SUPPLIER RIVER OAKS AT SHADY RIDGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 225 SHADY RIDGE ROAD NW HUTCHINSON, MN 55350
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(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	<p>Initial Comments</p> <p>On January 7, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL326816946M/HL326811492C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____