Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333115281M
Compliance #: HL333117222C

Date Concluded: November 7, 2024

Name, Address, and County of Licensee Investigated:

Lewiston Senior Living
505 E Main St
Lewiston, MN 55952
Winona County

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

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 developed an infection and required hospitalization with an infected wound on her left knee.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a fall two weeks earlier and sustained an abrasion on her left knee. The nurse was monitoring the abrasion weekly, and the facility provided appropriate interventions. When the resident had a change of condition and was sent to the hospital for further evaluation.

The investigator conducted interviews with administrative staff. The investigator contacted the resident's family member. The investigation included review of resident's records, incident reports, and the resident's external medical record.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia and arthroplasty of knee. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, and medications. The service plan also included two hours safety check at night.

One night, a staff member found the resident had fallen in her bathroom. Vital signs were taken and were normal at the time. The provider was notified, and a fall risk assessment was completed the same day.

A day after the fall, the wound monitoring indicated bruising was found on the resident's right calf and mid-thigh. She also had an abrasion on her left knee, related to the fall.

Five days after the fall, the wound monitoring document indicated the presence of a dry, pink scab on her left knee.

Eleven days after the fall, the wound monitoring document indicated left knee abrasion scab loosened, with redness and discolored wound base. The nurse notified the family member and sent a picture of the left knee, which showed greenish drainage. In the meantime, the facility applied bacitracin and a bandage.

The following day, a progress note indicated an unlicensed caregiver reported the resident had a low blood pressure, was fatigued and appeared sleepy. The nurse was notified of the change of condition and the resident was sent to the hospital for further evaluation.

The hospital records indicated the resident presented to the emergency room with an injury to her left knee, where a small wound had draining serosanguineous (blood and clear liquid) drainage. A family member accompanied the resident reported that there had initially been a scab after the fall. The resident also experienced pain over the top area of her knee. She was admitted to the hospital due to an infection in the wound near her left patella. The resident had no fever, chills, or other systemic symptoms.

During an interview, the family member stated that he received a message from a facility nurse, which included a picture of the resident's knee and expressed concern about the wound. He said that shortly after, the resident was sent to the hospital. He said that he did not know whether the resident had experienced any pain related to the wound but knew that she did not have a fever.

During an interview, a manager, who was also a nurse, stated that the resident had fallen two weeks ago and sustained an abrasion on her knee. When the scab fell off, which was the day before she was sent to the hospital, the wound began to drain, and she notified the family of her concern. At that time, Bacitracin and a bandage were used as interventions. The next morning, the resident had low blood pressure and was not acting like her usual self, so the

nurse decided to send her to the hospital. It was there that she learned the resident's knee had become infected.

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, the resident was unable to be interviewed due to dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted weekly wound assessments and closely monitored the resident. The resident was sent to the hospital for further evaluation when she experienced a change in condition.

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
	33311	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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 September 26, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL333115281M/HL333117222C, and #HL333115242M/HL333117164C. No correction orders are issued.	0 000		