Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334263364M
Compliance #: HL334265416C

Date Concluded: December 22, 2022

Name, Address, and County of Licensee Investigated:
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive

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.

Initial Investigation Allegation(s):
The staff member/alleged perpetrator (AP) abused Resident #1 when the AP pulled up the resident's pants roughly. The AP neglected Resident #2 when the AP did not provide scheduled services causing skin breakdown.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were inconclusive. Staff and residents interviewed provided conflicting accounts of the incidents and the AP denied the allegations.

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigation included review of the AP's employee file and resident records.

Resident #1 resided in an assisted living facility. The resident's diagnoses included multiple sclerosis and depression. The resident's service plan included assistance with bathing, catheter care, dressing, toileting, transferring, and medication administration.

Resident #2 resided in an assisted living facility. The resident's diagnoses included dementia, congestive heart failure, and post-traumatic stress disorder. The resident's service plan included assistance with medication administration, dressing, grooming, and toileting.

During an interview, the nurse stated she received a report from Resident #1 that the AP was rough when the AP pulled his pants up which caused his catheter to pull. Resident #1 reported he told the AP to stop, and the AP did not. Resident #2 reported to the nurse that the AP did not perform peri-cares properly.

During an interview, unlicensed personnel (ULP) stated she worked with the AP during the night shift. The ULP stated the AP was always in a hurry and quick with cares. The ULP witnessed the AP pull Resident #1's pants way up and recalled Resident #1 told the AP not to do that. The AP told the resident she was just trying to help. The ULP stated she never witnessed the AP refuse to assist any residents with scheduled services.

During an interview, the AP stated she had worked on and off at the facility for 15 years and has never had any complaints against her. The AP denied being rough to Resident #1 and stated she was just trying to help pull Resident #1's pants up at the time of the alleged incident. The AP denied refusing to provide services to Resident #2.

During an interview, Resident #1 stated he was treated well by staff and did not remember the incident involving the AP.

During an interview, Resident #2 stated the staff treat him with respect, but some needed more training. Resident #2 did not recall the incident involving the AP.

In conclusion, the Minnesota Department of Health determined abuse and neglect were inconclusive.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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: No, residents declined
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP is no longer employed at the facility.

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
	33426	A. BUILDING: _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: HL334265415C, #HL334263364M/#HL334265416C, #HL334263365M/#HL334265417C, On October 27, 2022, 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 17 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL334263365M/#HL334265417C, tag identification 2320.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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=G	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 ensure care and services were provided according to an up-to-date service plan, and acceptable health care and medical, or nursing standards, and supervision for one of one resident (R1) reviewed. R1 was diagnosed with cellulitis from bed bug bites. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: The Minnesota Adult Abuse Reporting Center Report indicated bed bugs were found in the resident's room by facility staff. Pest control was called and did not find any bed bugs. Eventually a colony of bed bugs were found near R1's room. R1 stayed in her apartment until the room was heat treated and had been getting bit by bed bugs	02320		

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02320	Continued From page 2 up until October 6, 2022. The nurse practitioner saw R1 on October 5, 2022, and diagnosed R1 with cellulitis on the lower extremities due to bed bug bites. R1 was started on antibiotics. R1 admitted with diagnoses including diabetes, depression, and anxiety. R1's service plan dated May 27, 2021, included assistance with bathing, medication administration, skin care and support stockings. R1's assessment dated October 6, 2022, indicated a diagnosis of cellulitis to both lower legs due to bed bugs bites. R1's treatment summary indicated unlicensed personnel (ULPs) were to apply ace wraps in the morning and remove the ace wraps in the evening. R1's October 2022, treatment summary indicated an ULP put on ace wraps one time, R1 refused six times and there was no documentation of the task being completed for the additional 19 days out of the month. R1's progress notes indicated: - September 24, 25, and 26, 2022, written by unlicensed personnel (ULP)-A, indicated R1 refused leg wraps as she did not want staff coming in her room and bringing the bed bugs out. - September 30, 2022, written by ULP-A, indicated R1 refused leg wraps and stated her legs itched too bad due to the bed bugs. R1 asked the ULP when the bed bugs will go away. ULP-A reminded R1 they needed to figure out something to do with R1's belongings due to her bedroom needing to be sprayed. - October 3, 2022, written by ULP-A indicated R1's legs were bitten and bleeding from	02320		

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02320	Continued From page 3 consistently scratching of the bites. The note indicated R1 had bag with bed bugs in it. ULP-A reminded R1 she needed to get rid of some of her items or her room could not be sprayed, or heat treated to remove the bed bugs. - October 5, 2022, the provider ordered two antibiotics and a cream for both lower legs for a diagnosis of cellulitis. - October 9, 11, 12, 18, 2022, R1 refused leg wraps due to legs not being healed. - October 19, 2022, the provider ordered an additional cream for the treatment of cellulitis to R1' legs. - October 21, 2022, R1 was transferred to the emergency room for worsening cellulitis. R1's record indicated a licensed nurse did not assess R1's legs after they became aware bed bugs were found from September 24, 2022, through October 5, 2022. An assessment was eventually completed on October 6, 2022, however, a licensed nurse did not re-assess or continue to monitor R1's legs from October 7, 2022, through October 18, 2022, after the diagnosis of cellulitis. The resident's cellulitis worsened, and R1 was sent to the emergency room for evaluation. Pest control records indicated on September 24, 2022, one room was sprayed for bed bugs and hallways and common areas were inspected. R1's room was not sprayed. On October 6, 2022, six room were heat treated, including R1's room. During an interview, registered nurse (RN)-C stated when bed bugs were found, pest control	02320		

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02320	Continued From page 4 was called right away. The pest control company sprayed areas and then heat treated the areas later. RN-C stated R1 complained of bed bug bites and the provider saw the resident. RN-C stated she was aware of the bed bugs and that she only worked one to two days a week and the other nurse should have been checking the resident's legs. During an interview, RN-D stated she was aware of bed bugs but did not assess R1's legs and said the other RN (RN-C) did. RN-D stated if staff assessed R1's legs it should be documented in the progress notes. R1's medical record lacked documentation of when nursing became aware of the bed bugs. R1's medical record also did not include initial assessment and monitoring of R1's legs after nursing staff became aware of the bed bugs and there was no documentation of assessment or monitoring following the original diagnosis of cellulitis and ordered treatments or documentation of the worsening condition of R1's cellulitis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		