DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352309202M

Compliance #: HL352307721C

Date Concluded: April 16, 2025

Name, Address, and County of Licensee Investigated:
Urbana Place Senior Living
5601 94th Avenue N.
Brooklyn Park, MN 55443
Hennepin County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, individual responsibility

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):
An alleged perpetrator (AP), a facility nurse, neglected the resident when they failed to update the resident's medical provider about a developing pressure sore on the resident's left ankle, which led to a delay in initiating orders for appropriate wound care. The resident developed an unstageable pressure sore.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator (AP), a facility nurse, was responsible for the maltreatment. Nursing leadership instructed the AP to obtain measurements of the resident's pressure sore and update the resident's medical provider to initiate an order for home health to provide wound care. The AP took measurements of the resident's pressure sore but failed to update the resident's medical provider. The resident's pressure sore was left untreated for several weeks until facility staff alerted nursing leadership the resident's wound was not being treated. The resident's pressure sore developed into an unstageable pressure sore (full thickness tissue loss where the depth of

the wound is covered by hard dry, black scab) and required weekly wound care for several weeks.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The AP was interviewed. The investigation included review of the resident's facility record, death record, photos of the resident's pressure sore, hospital record, home health record, facility internal investigation, facility incident reports, AP file, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included severe protein-calorie malnutrition (deficiencies in protein and calories). The resident's service plan included assistance with personal cares, escorts, and toileting. The resident's assessment indicated she had impaired memory and cognition but was able to make her needs known and be understood. The resident had no skin issues at the time she was assessed. The resident was unable to report neglect due to her impaired memory. The resident used a wheelchair for mobility and a sit to stand for transfers.

The resident's progress note indicated the facility informed the AP the resident had an open wound on her leg. The resident denied she had an open wound and refused to let the AP assess her legs. The resident's progress note lacked documentation the AP reattempted to assess the resident's legs or communicated to leadership the resident refused to be assessed.

The resident's record indicated no additional information was documented regarding the resident's wound until two weeks later.

A progress note documented two weeks later indicated the AP went to assess the resident's legs as requested by leadership two weeks earlier, but the resident refused stating she had no skin issues on her legs. No further reattempts were documented by the AP or documentation the AP asked another floor nurse to assess the resident, or update nursing leadership of the resident's refusal. In addition, the resident's record lacked documentation the resident's medical provider was updated.

The following day, the AP measured the resident's wound. The wound measured 2 centimeters (cm) x 1.5 cm x 0.3 cm. Nursing leadership requested the AP follow-up with the resident's medical provider to request recommendations and referral to a home health agency for wound assessment and management. The resident's record lacked documentation the AP followed through with nursing leadership's request to update the resident's medical provider for wound care orders.

Progress notes three weeks later, indicated nursing leadership received an email from a facility nurse regarding the resident's wound, inquiring if leadership knew about the resident's pressure sore. Upon review, the resident's record indicated the AP assessed the wound but

never documented the wound's progress, current treatment, or follow-up of the wound. Nursing leadership immediately updated the resident's medical provider to initiate expedited orders for home health to manage the resident's wound. Nursing leadership completed wound care and took photos of the resident's ankle wound. Measurements of the resident's pressure sore indicated it increased length, width, and depth measuring 2 cm x 2 cm x 0.5 cm. Leadership indicated the resident's pressure sore appeared to be a full-thickness skin loss wound, stage 3 with sloughing (dead tissue) and redness surrounding the area.

The resident's record indicated home health began wound care one week later.

During an interview, leadership stated one day she requested the AP assess the resident's leg wound reported to her by unlicensed personnel and follow facility protocols for wound orders. Leadership stated weeks later she found out the AP failed to update the resident's provider or obtain an order for wound care, so she immediately conducted an internal investigation. Leadership stated the AP admitted she did not make any further attempts to assess the resident's wound before she documented the resident refused and stated the AP seemed to not understand she needed to make two additional attempts to assess the resident's wound before documenting refusals. Leadership stated the AP was retrained on wound care when the AP returned to work. Leadership stated the AP refused to listen or take responsibility and resigned before leadership was able to suspend then terminate the AP.

During an interview, nursing leadership stated she attended a new hire orientation training and was in and out of the facility during the weeks of the incident stating her first day of work began approximately one week after the resident's pressure sore was first discovered. Nursing leadership stated floor nurses were expected to monitor and update nursing leadership whenever a resident experienced a change in condition and stated nursing leadership often delegated tasks to floor nurses. Nursing leadership stated one day unlicensed personnel notified her of a wound concern for the resident requiring a nurse follow-up. Nursing leadership stated she immediately asked the AP to measure the resident's ankle wound and follow-up with the resident's medical provider for an order for home health referral. Nursing leadership stated three weeks later she received another notice from unlicensed personnel asking nursing leadership if she was aware of the resident's ankle wound. Nursing leadership stated she immediately contacted the medical provider, measured the wound, took photos, and updated regional nursing leadership. Nursing leadership stated she took accountability for not following up with the AP but stated she fully expected the AP complete the nursing task because the AP told her she would do so.

During an interview, the AP stated leadership requested her to assess a wound on the resident's leg. The AP stated unlicensed personnel said the resident had a wound on her leg but did not state the location of the wound. The AP stated the resident became angry when the AP asked the resident if she could look at her leg wound, stating the resident insisted she did not have a wound. The AP stated she documented the resident's refusal and told leadership the resident did not have a wound. The AP admitted she failed to make further attempts to assess the

resident's wound after the resident first refused. The AP stated two weeks later, nursing leadership requested the AP assess and obtain measurements of the pressure sore. The AP stated she took measurements, gave them to nursing leadership assuming nursing leadership would update the resident's provider since they asked her for the wound measurements, even though the AP acknowledged it was one of her nursing duties. The AP stated she resigned because of the wound incident in addition to an issue regarding a misplaced order.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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 hospitalized during the onsite investigation then died at the hospital.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The AP is no longer employed by the facility.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: ______ B. WING ______	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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: #HL352307342C/#HL352309044M #HL352307721C/#HL352309202M #HL352307767C/#HL352309222M On March 13, 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 87 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL352307721C/#HL352309202M, tag identification 2310 and 2360.	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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a facility licensed practical nurse (LPN)-A, reported a pressure sore to one of one resident (R1)'s medical provider to initiate orders for home health management of R1's wound. LPN-A was instructed twice by licensed assisted living director (LALD)-C and registered nurse (RN)-B to evaluate and update R1's medical provider. LPN-A evaluated R1's pressure sore but failed to update R1's medical provider which led to a delay in initiating R1's wound care for several weeks. R1 developed an unstageable pressure sore requiring weeks of weekly wound care. 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: R1's medical record was reviewed. R1 was admitted to the licensee's facility on August 6, 2021. R1's diagnoses included severe protein-calorie malnutrition. R1's service check off list dated December 2024 indicated R1 received	02310		

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02310	Continued From page 2	02310		

assistance with personal cares, toileting, safety checks, and escorts. R1 used a wheelchair for mobility and a sit to stand lift for transfers.

R1's assessment dated December 19, 2024, indicated R1 had limited range of motion, impaired mobility, and weakness. R1 had no skin issues at the time she was assessed.

R1's progress note dated December 30, 2024, at 2:57 p.m., indicated LPN-A was informed R1 had an open wound on a leg. R1 denied having a wound and refused to have LPN-A assess her legs. R1's progress note lacked documentation LPN-A made additional attempts to assess R1's legs or communicated with facility leadership R1 refused to be assessed.

R1's record indicated no additional information was documented about R1's wound until two weeks later.

R1's progress note dated January 16, 22025 at 6:03 p.m., documented by LPN-A, indicated LPN-A attempted to reassess R1's legs as previously requested by LALD-C on December 30, 2024, but R1 refused stating she had no skin issues on her legs. No further reattempts were documented by LPN-A, or documentation LPN-A asked another floor nurse to assess R1, or update RN-B, LALD-C, and R1's medical provider.

R1's progress note dated January 17, 2025, at 10:13 a.m., documented by registered nurse (RN)-B, indicated a wound was noted to R1's left outer ankle. LPN-A's measurements of R1's wound indicated the wound was 2 centimeters (cm) x 1.5 cm x 0.3 cm. No further description of R1's wound was documented. RN-B indicated

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02310	Continued From page 3	02310		

LPN-A would follow-up with R1's medical provider to notify them of R1's wound and request recommendations and request for referral to home health agency for wound assessment and management.

R1's record lacked documentation LPN-A contacted and updated R1's medical provider about R1's wound and to initiate wound care for R1's pressure sore.

R1's progress note dated February 7, 2025, at 9:19 a.m., indicated RN-B contacted R1's medical provider to provide an update on R1's wound and to request a home health wound evaluation. RN-B indicated R1's medical provider was never notified about R1's wound until RN-B called and updated the provider.

R1's progress note dated February 7, 2025, at 10:54 a.m., documented by RN-B, indicated upon review of R1's record, there were no progress notes documented by LPN-A indicating she followed up with R1's medical provider or notes a current treatment plan was implemented for R1's pressure sore. New measurements obtained of R1's wound indicated the length, width, and depth of the wound increased, measuring 2 cm x 2 cm x 0.5 cm. RN-B indicated R1's pressure sore appeared to be a full-thickness, stage 3 wound with adherent sloughing (presence of necrotic, dead tissue).

R1's progress note dated February 13, 2025, at 1:16 p.m., indicated home health began treatment for R1's pressure sore on February 13, 2205, at 2:30 p.m.

During an interview on March 20, 2025, at 8:11 a.m., LPN-A stated on December 30, 2024,

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02310	Continued From page 4 LALD-C requested she evaluate a wound found on R1's leg by unlicensed personnel (ULP). LPN-A stated an ULP said R1 had a wound on her leg but did not state the location of R1's wound. LPN-A stated R1 became angry when LPN-A asked R1 if she could look at R1's leg wound, stating R1 insisted she did not have a wound. LPN-A stated she documented R1's refusal and told LALD-C R1 did not have a wound. LPN-A admitted she never made further attempts to assess R1's wound after R1 first refused. LPN-A stated on January 16, 2025, RN-B asked her to assess and obtain measurements of R1's wound. LPN-A stated she took measurements of R1's wound and handed the measurements to RN-B, stating she assumed RN-B would update R1's medical provider since RN-B asked her for the measurements of R1's ankle wound, even though she acknowledged it was one of her nursing duties. LPN-A stated she resigned because of R1's wound incident in addition to an issue regarding a misplaced order, stating she felt badly treated by facility leadership. During an interview on March 31, 2025, at 11:00 a.m., RN-B stated she began working at the facility on January 6, 2025, one week after R1's pressure sore was first discovered. RN-B stated floor nurses were expected to monitor and update nursing leadership whenever a resident experienced a change in condition, stating she often delegated tasks to floor nurses. RN-B stated on January 16, 2025, she received a "Wisdom to Act" notice from an ULP indicating a wound concern on R1's ankle requiring a nurse follow-up. RN-B stated she immediately asked LPN-E to obtain measurements of R1's ankle wound then follow-up with R1's medical provider for an order for home health referral. RN-B stated on February 7, 2025 she received another	02310		

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02310	Continued From page 5	02310		

"Wisdom to Act" notice from an ULP inquiring if RN-B was aware of R1's ankle wound or if it was addressed. RN-B stated she immediately contacted R1's medical provider, measured R1's ankle wound, took photos, and updated regional nursing leadership. RN-B stated she took accountability for not following up with LPN-A but stated she fully expected LPN-A to complete the nursing task because LPN-A told her she would do so.

During an interview on April 1, 2025, at 3:00 p.m., LALD-C stated on December 30, 2024, she requested LPN-A assess a wound on R1's leg reported to her by an ULP and follow facility protocols for wound orders. LALD-C stated on February 7, 2025, she found out LPN-A never updated R1's medical provider or obtain orders for wound care, so she immediately conducted an internal investigation. LALD-C stated LPN-A admitted she did not make any further attempts to try and assess R1's wound before she documented R1 refused, stating LPN-A seemed to not understand she needed to make two additional attempts to assess R1's wound. LALD-C stated nursing leadership retrained LPN-A on wound care but stated shortly after RN-B found unprocessed orders stacked in the nurse's station LPN-A and two other LPN's overlooked. LALD-C stated LPN-A worked multiple day and evening shifts during the time the orders came through. LALD-C stated LPN-A refused to listen or take any responsibility for the orders not being completed. LALD-C stated the two other LPN's were suspended then retrained on processing orders stating the other LPN's took responsibility and seemed remorseful. LALD-C stated LPN-A resigned before she could be terminated.

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02310	Continued From page 6 The licensee policy titled Wound Care and Pressure Injury, updated August 2023, indicated the nurse was to notify the resident's physician as soon as possible but not to exceed 24 hours whenever a resident was assessed with alterations in skin integrity. No additional information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		