

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368494867M
Compliance #: HL368498409C

Date Concluded: January 12, 2024

Name, Address, and County of Licensee

Investigated:

Personal Care Management LLC
525 Cutter Street
Anoka, MN 55303
Anoka County

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

Evaluator's Name: Brooke Anderson, 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), a facility nurse, neglected the resident when the AP did not have address the resident's skin concerns, which resulted in pressure injuries to the resident's buttocks and heel.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident developed pressure injuries (wounds), there was not a preponderance of evidence the injuries were a result of neglect by the AP. The areas of injury were assessed, the resident's provider was updated, and wound care management was coordinated with outside agencies.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the home care agency. The investigation included review of the resident's medical record, hospital records, personnel files,

and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety disorder, and depression. The resident's assessment indicated the resident's cognition was moderately impaired. The resident's service plan included assistance with transfers, bed mobility, and safety checks.

Medical records indicated the resident admitted to the facility following hospitalization for excoriation (lesions on the surface of the skin) of the buttocks. Medical records indicated the resident received assistance with turning and repositioning, but the resident often declined assistance. A moisturized barrier cream was applied to the affected area twice per day prior to development of the pressure injury. The barrier cream was also available at the resident's bedside for the resident to apply as needed. The resident's physician was updated when any changes were observed during assessment of the resident's skin.

Two months after the resident's admission to the facility, progress notes indicated the facility received orders for skilled nursing to evaluate and treat a wound on the resident's buttocks. The resident was also prescribed a high protein nutritional drink and provided a hospital bed with a pressure relieving mattress to promote wound healing. The resident's skin was assessed by nursing staff and when another area of injury was observed, the resident's provider was updated.

One month later, the resident had a noted decline in health status and was admitted to hospice services. Hospice staff took over management of the resident's wound care and completed dressing changes. The pressure injuries healed, and the resident discharged from hospice services.

During an interview, the facility nurse/alleged perpetrator (AP) stated the resident's wounds were assessed and treated and the healthcare provider was updated on any change in status of the wounds. The nurse indicated the resident's care plan was updated and wound care management was coordinated with an outside agency and hospice staff.

During an interview, the resident stated she admitted to the facility with skin concerns which healed after her admission to hospice care. The resident had no concerns related to the wound care provided at the facility.

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: Yes.

Family/Responsible Party interviewed: No, attempts to contact were unsuccessful.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility updated the medical provider and coordinated wound care with an outside agency.

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: 36849	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2023
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NAME OF PROVIDER OR SUPPLIER PERSONAL CARE MANAGEMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 525 CUTTER STREET ANOKA, MN 55303
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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 November 28, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL368498409C/HL368494867M, #HL368495390C/HL368498244M. No correction orders are issued.</p>	0 000		

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