

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL387836322M
Compliance #: HL387839427C

Date Concluded: February 10, 2025

Name, Address, and County of Licensee

Investigated:

Camilia Rose Assisted Living
11800 Xeon Blvd NW #203
Coon Rapids, MN 55448
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Substantiated, facility 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):

The facility neglected the resident when staff failed to monitor the resident's skin and provide necessary care to promote healing and/or prevention resulting in development and worsening pressure wounds.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's care plan, physician's orders, and wound care treatment plan were not followed by facility staff, resulting in the worsening and development of additional wounds.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted outside agency staff. The investigation included review of the resident record(s), outside agency health records, hospital records, facility internal investigation documentation, facility incident reports, personnel files,

staff schedules and related facility policy and procedures. Also, the investigator observed the facility environment, staff interactions, care delivery and medication administration systems.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia and dementia. The resident's nursing assessment indicated the resident was cognitively impaired. The resident's service plan included medication management, assistance with bathing, toileting, two-person transfers, safety checks, and behavior management. The resident required assistance with bed mobility, including turning and repositioning and while in bed the resident should be turned from right side to her back. The resident used a mechanical lift for transfers and had bed rails for bed mobility assistance. The resident also utilized a motorized wheelchair independently for mobility. The resident also received supplements three times per day to promote wound healing. The resident had a suprapubic (tube placed through the abdomen into the bladder) catheter which was emptied and monitored by facility staff. The resident also received additional care services from an outside home care agency.

The resident admitted to the facility with orders for preventative treatment to the coccyx area (at the base of the spine). Over the next three months, the resident developed approximately seven different pressure wounds.

An outside agency became involved in the management of the resident's wounds. The outside agency provided orders for interventions, repositioning schedules, and orders for wound cleansing and treatment to facility staff to assist in the management and treatment of the resident's wounds.

Facility records lacked evidence that staff implemented interventions, repositioning, or wound care monitoring, assessment, or treatment as ordered by the outside agency care team. Records from the outside agency identified that facility staff did not implement the interventions as ordered and dressings were found soiled and falling off by the outside agency staff.

During an interview, a facility management nurse stated she could not recall if an audit was completed to ensure facility staff were following the resident's plan of care for the pressure prevention and wound care treatment, including monitoring the resident's repositioning schedule.

During an interview, an outside agency wound nurse stated the resident started with a small superficial wound on the buttock area, but not long after a pressure wound developed and worsened. The agency, wound nurse stated finding the resident's skin covered in stool on her buttocks area and the resident's pressure relief boots were not always applied as recommended and the resident developed multiple pressure wounds while residing at the facility.

During an interview, the resident's family member stated the resident had the diagnoses of paraplegia for approximately sixty years and had been without pressure wounds up until admission to the facility. The family member had concerns over the developing pressure wounds and did not feel the facility could facilitate wound prevention or treatments. The family member stated she communicated concerns regarding pressure wound prevention and treatment listed on the resident's plan of care. The family stated she expressed concerns with the resident's increase in pressure wounds and unlicensed personnel completing the resident's skin checks.

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. Per family member request and the resident's cognition.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

None.

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

Anoka County Attorney

Coon Rapids City Attorney

Coon Rapids Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38783	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2024
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NAME OF PROVIDER OR SUPPLIER CAMILIA ROSE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 11800 XEON BLVD NW COON RAPIDS, MN 55448
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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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL387839427C/#HL387836322M</p> <p>On December 5, 2024, through December 19, 2024, 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 18 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL387839427C/#HL387836322M, tag identification 2360.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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02360	Continued From page 1	02360		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interviews, and document review, the licensee failed to ensure one resident out of five residents reviewed was free from maltreatment. R1 was neglected.</p> <p>Findings include:</p> <p>On December 19, 2024, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the licensee was responsible for the maltreatment, in connection with incidents which occurred at the licensee. The MDH concluded there was a preponderance of evidence that maltreatment occurred.</p>	02360		