Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397187082M
Compliance #: HL397181742C

Date Concluded: April 7, 2025

Name, Address, and County of Licensee Investigated:

Living Hope Homes
1805 60th Street East
Inver Grove Heights, MN 55077
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 facility staff failed to follow the resident's plan of care and provide necessary care and services to prevent wounds to the resident's feet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to remove the resident's socks for about two weeks and check his skin. The resident developed an infection and wounds to his left foot.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, staff schedules, and related facility policy and procedures. Also, the investigator made an unannounced onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis. The resident's assessment indicated the resident required one to two staff for assistance with bathing and dressing. The resident's assessment indicated the resident was cognitively intact, had left sided weakness, was unable to walk and required a mechanical lift for transfers.

The facility investigation indicated one day when a family member removed the resident's left sock from his foot, a large wound was exposed. The facility investigation indicated the resident's family member stated the resident had the same socks on his feet for a couple of weeks. The resident stated he had requested bed baths and that the staff had not washed his feet. The facility investigation indicated during the resident's bed baths and daily dressing staff had not removed or changed the resident's socks. The resident was sent to the hospital for an evaluation.

The hospital record indicated the resident was seen for wounds on the top side of his left foot. A picture with the hospital records indicated the resident had wounds to all five toes of the left foot. The top side of the foot, at the base of the toes, there was a wound. The hospital records indicated the second toe was the worse of the wounds. The wounds were cleansed, and a wound bandage was applied. The resident was treated for cellulitis (a bacterial infection of the skin and underlying tissues) and sent back to the assisted living with antibiotics.

During an interview, the nurse stated the resident often did not like to wear socks, but one day it had gotten cold out and the family member applied socks to the resident's feet. It was determined that resident had the same socks on for about two to three weeks. When the family member came to the facility they noticed the resident had on the same socks. When removing the socks, the family member noticed the resident's skin on his left foot was coming off with the sock. The resident's left foot bruise on his big toe, but the skin was intact. When the resident's socks were removed, his feet were cold, purple and swollen and there were circulation issues. The left foot was worse than the right foot. The resident's socks and feet were moist and sweaty. The nurse stated it was determined that staff were not changing the resident's socks following the bed baths. In addition, the staff were not changing the resident's socks when they assisted him with daily dressing. The nurse stated the expectation was that staff would put on new socks in the morning and take them off at night. If the resident wanted to wear his socks at night, staff would remove the old socks and put on new socks. It was expected that during a bed bath, staff would remove the resident's sock and wash the resident's feet, then apply clean socks. The nurse stated staff failed to provide the resident with skin checks.

During an interview, the family member stated the resident's wounds were from a lack of hygiene and not bathing the resident properly. The family member stated the hospital indicated it was miracle that the resident did not lose his toes.

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. Resided at a different facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The resident was sent to the hospital after identifying the wounds. Following the resident’s return from the hospital, wound care was completed, education to staff was completed, added to the resident’s care plan that dressing included changing socks, and weekly skin checks were completed. The facility also notified the resident’s physician of the resident’s wounds.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Inver Grove Heights City Attorney
Inver Grove Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39718	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES OAK GROVE	1805 60TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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: #HL397187082M / #HL397181742C On March 11, 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 five residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL397187082M/#HL397181742C, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		