

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL399593162M
Compliance #: #HL399595907C

Date Concluded: August 27, 2025

Name, Address, and County of Licensee

Investigated:

Bismol Home Care
5542 Unity Avenue N
Crystal, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson, 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 facility neglected the resident when staff failed to follow the prescribed care plan and failed to provide wound care as ordered.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility followed the resident's care plan. The resident was continually monitored and treated according to the resident's individual assessed needs.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator also contacted a member of the resident's care management team. The investigation included review of the resident's medical records, hospital records, and related facility policies and procedures. The investigation included an onsite visit where the investigator toured the facility and observed staff providing care and services to the resident including wound care.

The resident resided in an assisted living facility. The resident's diagnoses included a pressure ulcer, Stage 4 (a large open wound that may affect bone and muscle), Type 2 diabetes, right lower limb amputation, and respiratory failure. The resident's service plan included assistance with dressing, grooming, medication management, urinary catheter care, colostomy care, repositioning and wound care. The resident's assessment indicated the resident was orientated to person and place, was non-ambulatory although could use an electric wheelchair. The resident required frequent supportive nursing care and observation.

The resident's medical record indicated that the resident was admitted to the facility over two years prior with a documented stage 4 pressure wound. Since arriving at the facility, the resident had multiple hospital stays and was followed at more than one wound care clinic for a non-healing pressure wound complicated by a diagnosis of diabetes and a confirmed Methicillin-resistant Staphylococcus aureus (MRSA) diagnosis (a bacteria that is resistance to conventional antibiotic therapy which inhibits the rate of tissue repair and will further prolong healing time).

Review of the resident's medical record indicated staff followed physician's orders and provided wound care as directed. Any changes in the appearance of the wound or changes in the resident's condition were reported to the physician and the resident was sent to the hospital to further evaluation if needed.

During an interview, the facility nurse who performed the initial admission assessment of the resident, stated the resident presented to the facility with an already existing stage four wound which effected his coccyx (tailbone area). She described the wound at the time of admission to the facility as the size of a dinner plate or sheet of office paper. The facility has since been able to maintain the wound from progressing. The nurse stated that she was also present during hospital care conferences after the resident was admitted for treatment and the treatment options were extensive including amputation which the resident has refused.

During an interview, a nurse at the facility stated the resident had multiple hospital admissions over the past two years for other disease related issues. The resident requested to return to the facility and the facility collaborated in discharge planning to ensure the hospital's scope of wound care orders could be maintained. The nurse further indicated that over the past two years there had been occasions where wound care supplies were delayed from the vendors and the facility would purchase the needed supplies on their own if needed. Due to the complexity of care needed the nursing staff continually offered to re-educate the resident on the importance of complying with wound care orders and repositioning.

During an interview, the resident stated that his wound appeared before he was admitted to the facility over two years ago. The resident stated that registered nurses completed daily wound care. The resident had no concerns with the overall care he received and acknowledged the importance of adhering to the care plan including scheduled provider appointments and repositioning.

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: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility purchased additional wound care supplies as needed and obtained additional training by attending additional wound care treatment courses.

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: 39959	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/04/2025
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NAME OF PROVIDER OR SUPPLIER BIMSOL HOME CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5542 UNITY AVENUE NORTH CRYSTAL, MN 55429
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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 August 4, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL399595907C/#HL399593162M. No correction orders are issued.</p>	0 000		

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