Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200113322M
Compliance #: HL200113470C

Date Concluded: September 4, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Worthington
1801 College Way
Worthington, MN 56187
Nobles County

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

Evaluator's Name: Danyell Eccleston, RN, 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 the facility failed to provide adequate skin care when the resident developed a stage three pressure injury (a skin injury that goes through the full thickness of the skin to the fat layer) to her buttocks. The wounds became infected, and the resident went to the hospital for treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility sent the resident to the emergency department for a wound check ten days after becoming aware of the wounds. Upon emergency department arrival, the resident's wounds were infected, and she was found to have sepsis (a serious condition in which the body responds improperly to an infection). The facility failed to ensure the wounds were kept clean from foreign matter and did not follow-up with providers regarding the wound worsening prior to infection.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted clinic and hospital providers. The investigation included review of resident medical records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interacting with residents.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, chronic blood thinner usage, and obesity. The resident's service plan included assistance with bathing, dressing, grooming, toileting, and medication management. The resident's assessment indicated the resident had thin fragile skin and had bowel and urinary incontinence.

Progress notes indicated a staff member notified a facility nurse that the resident had an uncomfortable, open area on her buttocks. A nurse indicated there were purple discolored spots on the residents' buttocks and, "two areas of alteration of intact skin on both sides." A dressing was placed on the right side as it appeared open, calmoseptine ointment (an ointment that is used to protect, treat, or heal skin) was applied. No further information about size or location of the wounds were included.

Progress notes dated five days after the wounds were first noted indicated the resident had two open areas on her buttocks. The wound on the resident's right buttock appeared to be increasingly larger and more open, bleeding when wiped. The left buttock wound no longer had a first layer of skin and had a hard, maroon colored scab. The note indicated staff were repositioning and transferring the resident, "often," and wound dressings were attempted but did not stay adhered for more than one toileting. The note indicated staff applied calmoseptine ointment with every toileting and as needed and the calmoseptine ointment was not improving the wounds. A fax request for further orders was sent to the medical provider. No further information about size or location of the wounds were included.

Progress notes backdated dated to five days after the wounds were first noted indicated the provider sent a referral to wound care. The progress note was a late entry entered 14 days after the wounds were first noted.

Progress notes backdated to seven days after the wounds were first noted indicated the facility contacted a clinic for wound evaluation, but the clinic indicated they did not treat buttock wounds. No further information about contacting other wound providers or the resident's clinic was included in the resident's progress notes. The progress note was a late entry entered 14 days after the wounds were first noted.

Progress notes backdated to seven days after the wounds were first noted indicated the resident's wounds continued to degrade. The right buttock wound was open, wet, and draining clear fluid. The left buttock wound was the size of a golf ball, did not have a first layer of skin, and had a maroon hardened scab that looked like a large blood blister. The resident was

encouraged to continue repositioning. The progress note was a late entry entered 14 days after the wounds were first noted.

Progress notes dated ten days after the wounds were first noted indicated the resident was sent to the emergency room for a draining wound.

The resident's medication administration record during the month in question contained a line for calmoseptine ointment, and instructed, "apply to affected area(s) as needed as directed for rash." There was no documentation of administrations present on medication administration record (MAR) or further explanation of where to apply ointment located in medication administration record.

The residents service check-off documentation during the month in question indicated staff consistently documented completion of, "skin condition monitor," with instructions, "apply calmoseptine or nystatin powder if needed. Monitor skin condition(s) and report concerns to nurse." No further details were included about if powder or ointment was applied nor was a location of application included in documentation.

The residents service check-off documentation eight, nine, and ten days after the resident's wounds were first noted indicated staff documented completing, "apply calmoseptine after toileting. See MAR for specific medication instructions."

The residents service check-off documentation nine and ten days after the resident's skin issue was first noted indicated staff documented on two occasions completing, "Wound care- cleanse area with wound cleanser and pat dry with gauze, apply silvadine 1% cream (cream used to treat and prevent serious infection on areas of skin) topically to wound bed, cover with ABD [a thick, absorbent pad used to cover wounds], secure with cloth tape. Change daily and PRN [as needed]."

The resident's hospital records indicated the resident was admitted with buttock wounds, sepsis, and low blood pressure. The resident reported having diarrhea at the facility which continued at the hospital. The resident's appearance was, "ill" appearing and "toxic-appearing." Review of photos taken at the hospital showed large red and purple areas to buttocks with open wounds covered in feces. The resident received intravenous fluids, antibiotics, pressure was off loaded from the resident's pressure injury, silver sulfadiazine (medication used to treat skin infections) and a Mepilex dressing (a wound dressing that absorbs wound discharge and seals around the wound margins to protect) were applied. The resident's hospital diagnosis included infected stage three pressure ulcer and severe sepsis.

The resident's clinic documentation indicated a facility nurse faxed the clinic to obtain wound care orders five days after the facility discovered the resident's buttock wounds and included information from that day's progress notes. The same day, the clinic sent back an order for

referral to wound care. The clinic had no further requests for wound care orders or wound updates from the facility.

During interview, a nurse stated staff were directed to wipe the residents' wounds and re-apply calmoseptine cream with every toileting and as needed. The nurse stated a dressing was initially applied to the wounds, but the dressings did not stay in place and it was felt the dressings were doing more harm than good due to sticking to other areas and rolling.

During interview, a second nurse stated the resident's buttocks were deep purple and red in color, the resident's wounds looked like, "really wet skin" and the first layer of skin was white, loose, and not intact. The second nurse state the resident was very frequently wet and incontinent.

During separate interviews, two unlicensed staff members stated during the time in question they did not apply a dressing to the resident's wounds.

During interview, a provider indicated the resident came to the hospital with extensive wounds to her buttocks and the wound areas appeared to have dead skin tissue and pus coming from the wounds. The resident also reported experiencing diarrhea at the facility that was worsening.

During interview, a second provider indicated the resident was at higher risk for developing infection and delayed wound healing due to her diabetes, obesity, and chronic blood thinner usage diagnoses.

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, vulnerable adult is deceased.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital for treatment.

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
Nobles County Attorney
Worthington City Attorney
Worthington Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20011	A. BUILDING: _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN WORTHINGTON THE MEADOWS	1801 COLLEGEWAY WORTHINGTON, MN 56187

(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: #HL200113222C/#HL200113161M, #HL200113470C/HL200113322M On July 15, 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 109 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL200113222C/#HL200113161M and #HL200113470C/HL200113322M , tag identification 2360.	0 000		
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	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were 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 reports for details.	02360	Assisted Living Provider 144G. 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.	

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