Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202579486M
Compliance #: HL202577230C

Date Concluded: April 19, 2024

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone ave N
New Hope, MN 55428
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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 unlicensed caregivers failed to report to the nurse the resident's refusal to remove the brace, resulting in a wound on the back of his right leg.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident began using used a knee brace and, while the physical therapy department was aware of this, the resident's knee brace was not incorporated into his nursing services. Later, when the knee brace was removed in an attempt to provide the resident a bath, the resident had developed an infected wound on his leg and required hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staffs. The investigation included review of the resident's records,

incident reports, staff schedules, policies, procedures, and the resident's external medical record.

The resident resided in an assisted living facility. The resident’s diagnoses included dementia, muscle weakness and diabetes. The resident’s service plan included assistance of one person with toileting and personal hygiene. The resident’s assessment indicated the resident was at risk for skin breakdown due to incontinent and deceased mobility.

The facility progress notes indicated the physical therapy department confirmed the resident had a knee brace in use. The same document indicated the resident needed a bath, initially refused, but then consented. When the knee brace was removed, the wound underneath was identified, and the resident was sent to the hospital to check for possible infection.

The resident’s hospital record indicated the resident had worn a brace without a physician’s order and did not take it off for a month resulting in a wound measuring 3.9 cm in length by 3 cm in width and 0.5 cm in depth on the back of his right knee due to immobility. The same document indicated the wound was open, pus was evident, and he required intravenous antibiotics.

Four months prior to this hospitalization, the resident’s physical therapy notes indicated a physical therapist assisted the resident to order the brace online to alleviate knee pain. Throughout those months, the therapist provided updates to unlicensed caregivers regarding the braces. Additionally, the therapist's notes indicated the resident was found soiled multiple times and had a dry bowel movement on their foot for several days.

A review of the resident’s most recent assessment and service plan at the time of the hospitalization did not identify entries addressing the resident’s use of a knee brace.

During an interview, the manager, who was also a nurse, stated she found out about the brace when the facility discovered the wound. Later, she was informed by physical therapy department later that the resident had purchased the brace online himself. The manager stated the unlicensed caregivers did not report the presence of the brace to her, and she was uncertain whether they had reported it to another nurse. She confirmed the unlicensed caregivers did not inform the nurses about the resident's refusal of the shower nor could she locate documentation regarding the resident’s refusal of showers. She also said the facility conducted skin assessments with quarterly assessments, which had been conducted six months prior, but otherwise did not conduct skin assessments unless alerted by alerted by caregiver. She acknowledged being aware of the resident's declining health. The manager stated the nurse responsible for his care should have conducted an assessment with his change in needs. when his care needs transitioned from one-person assistance to two-people and then to an EZ stand.

During an interview, a family member stated the resident had been at the facility for over a year and had experienced mobility difficulties, prompting him to work with a physical therapist. The

family member stated the resident began using a knee brace as it helped reduce his muscle spasms and pain. The family member said the resident had not been receiving adequate skin care from the staff. He had developed a significant open wound behind his right knee leading to a hospitalization. Earlier the same day of the resident's hospitalization, she visited the resident, but found him unresponsive in his recliner chair. He was soiled, and it required the effort of three to four staff members to remove his clothes and transport him to the whirlpool bath and that was when the wound was discovered.

During an interview, nurse #1 stated she was aware of the brace; she had heard about it but had not physically seen it in person. She knew the resident had purchased the brace himself and applied it on his own terms. Nurse #1 also said the resident was incontinent, and unlicensed caregivers were expected to check on him at least every shift or whenever he used the call light. She did not remember if unlicensed caregivers had reported to her about the resident refusing showers or care. Nurse #1 said that skin assessments were typically conducted during quarterly assessments by the nurse or when the resident had a shower, during which unlicensed caregivers would check the resident's skin and report any issues. She said unlicensed caregivers should notify the nursing team if the resident refused a shower.

During an interview, physical therapist assistant stated she had primarily worked with the resident. As his mobility gradually declined, causing him to quit walking due to pain, she suggested he try knee braces. He purchased them independently four months prior, and she ensured he understood how to properly wear and remove them. She educated him on not wearing them constantly. She observed him putting on and taking off the braces and noted that the resident found relief from pain while wearing them. She recalled discussing the braces with the nursing staff but could not recall the specific staff member. A month before the incident, the resident's mobility significantly declined, and he could no longer be able to stand. Physical therapist assistant said she told the unlicensed caregivers of this decline to prevent staff injury during care. She said the resident complained to her about using the call light without response from staff. She frequently observed he was soiled and had bowel movements on his shoes and clothes. She was not certain if he refused to be cleaned up or if staff neglected to assist him. On her last day working with him, he was very solid, requiring three to four people to assist him into a wheelchair and the bath. When they removed his braces, they discovered the wound, to which the resident seemed unaware.

During an interview, unlicensed caregiver #1 stated she worked mostly the morning shifts and never assisted the resident with dressing. When he became unable to stand, she requested assistance from the nurses for his care as needed. She would let the nurses know when the resident was unable to move. Unlicensed caregiver #1 stated she knew about the brace, and the resident managed it independently. However, she was uncertain whether the nurses were aware of the brace or not. She stated the resident always dressed himself and that the night shift reported he refused care, although he did not refuse for her. In the mornings, she checked on him four to five times for medications and assisted him with meals. On the day he was taken to the hospital, the night shift had not changed him, and it required assistance from multiple

people to get him up as he could not stand. That week, she found him wet and soiled on several occasions. She confirmed seeing his brace only once because staff members were not the ones who put the brace on.

During an interview, unlicensed caregiver #2 stated the resident used to walk and often sat in his recliner but she was not sure if he wore braces or not. She said sometimes he had bowel movements and attempted to conceal them. If she administered medication and detected an odor, she would then proceed to clean him up.

During an interview, nurse #2 stated she did not recall whether the resident had a brace or not. She said he never refused care when she was on duty. Nurse #2 said she often found the resident in need of assistance and would help him clean up if he was soiled. She confirmed no unlicensed caregivers informed her when the resident refused care and stated that unlicensed caregivers were expected to inform the nurse or document it if the resident refused care. If the resident refused a shower, nurse #2 said that unlicensed caregivers should assist him with bed baths, freshen him up, and provide him with clean clothes.

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, the resident no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital when the wound was discovered.

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
Hennepin County Attorney
New Hope City Attorney
New Hope Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 On March 27, 2024, the Minnesota Department of Health initiated an investigation of complaint HL202579486M/HL202577230C and HL202572344M/HL202571410C. The following correction orders are issued For HL202579486M/HL202577230C correction order identification 0730, 1620 and 2360. For HL202572344M/HL202571410C correction order identification 2360.	0 000		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	0 730		

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0 730	Continued From page 1 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document services were provided as identified on the service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 730		

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0 730	Continued From page 2 R1 admitted to the licensee's facility on March 11, 2022. R1's diagnoses included muscle weakness and difficulty walking. R1's Kardex record, undated, indicated that R1 was incontinent and managed both independently and by staff. It also indicated bathing assistance once per week on Tuesday mornings. R1's record lacked documentation of showering. In the email correspondence dated April 2, 2024, Licensed Assisted Living Director (LALD)-Q stated that there was no shower documentation available, as they did not have a system in place for unlicensed caregivers to mark whether they performed the shower or if the resident refused it. On April 9, 2024, at 4:05 p.m., Director of Nursing (DON)-A stated that the unlicensed caregivers were supposed to inform the nurse if the resident refused the shower, but she was unsure whether this was done for R1. DON-A also said that she could not locate any documentation related to the shower or refusal of shower for R1. The licensee's dated August, 2021 Resident Records Documentation policy indicated each resident's record would include documentation that services were provided as identified on the service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 3 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess one of one resident (R1) for change of condition related to mobility, as well as failed to implement interventions to prevent skin breakdown. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01620		

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01620	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee's facility on March 11, 2022. R1's diagnoses included muscle weakness and difficulty walking. R1's assessment dated May 1, 2023, indicated R1 was able to transfer, eat, use the toilet, perform oral care, dress, and move independently. The assessment also noted bruises and dry skin for skin evaluation, as well as a risk for skin issues due to incontinence, decreased mobility, and a decrease in subcutaneous fat. R1's service plan dated May 2, 2023, indicated R1 was to receive assistance from one person with oral hygiene, toileting/peri-care, showering once per week, transfers, and medication management. R1's Kardex record, undated, indicated that R1 was incontinent and managed both independently and by staff. It also indicated bathing assistance once per week on Tuesday mornings. R1's physical therapy treatment encounter notes dated July 5, 2023, indicated R1 had new knee braces and the physical therapist assistant (PTA)-G educated R1 on putting it on. R1's physical therapy treatment encounter notes dated September 27, 2023, indicated PTA-G found bowel on R1's foot/leg. R1's physical therapy treatment encounter notes dated September 29, 2023, indicated R1 still had	01620		

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01620	Continued From page 5 bowel on his foot and legs. PTA-G updated concerns with unlicensed caregivers on her concerns. R1's physical therapy treatment encounter notes dated October 4, 2023, indicated R1 a significant decline in mobility as R1 was unable to ambulate more than a few steps at a time. R1 also required skilled assessment during therapy sessions to ensure safe mobility. R1's physical therapy treatment encounter notes dated October 18, 2023, indicated R1 needed help standing and pulling up pants. R1's physical therapy treatment encounter notes dated October 23, 2023, indicated R1 was unable to stand up and experienced a significant decline. R1's physical therapy treatment encounter notes dated October 25, 2023, indicated R1 were now one to two persons for transfers and needed help with toileting, getting dressed. R1 was close to needing EZ stand. R1's physical therapy treatment encounter notes dated October 30, 2023, indicated R1 was found in recliner and smelled soiled. R1's pant was half on. R1 needed assisted of two persons with EZ stand. R1's physical therapy treatment encounter notes dated October 31, 2023, indicated R1 was found soiled with bowel movement and urine in his recliner. R1 was not able to stand. Hoyer was recommended. R1's physical therapy treatment encounter notes dated November 6, 2023, indicated R1 was unable to straighten right lower extremity. R1	01620		

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01620	Continued From page 6 rated pain 7-9/10 with straightening. R1's physical therapy treatment encounter notes dated November 8, 2023, indicated R1 was weak and soiled. R1 was unable to stand and needed three to four caregivers to assist to the shower. During shower, a wound was found on the back of right knee. R1's hospital record dated November 9, 2023, at 3:04 p.m., indicated R1 was admitted to the hospital emergency department (ED) with right posterior knee wound of unknow duration. The wound was 3.9 centimeter (cm) in length by 3 cm in width by 0.5 cm in depth. The wound base was light pink, granular with 30% slough. R1's record lacked documentation of assessments by the nurse when he began wearing a brace and when he transitioned from two-person assistance to eventually using an EZ stand for transfers. R1's progress notes from July 18, 2023, to November 6, 2023, did not mention anything related to R1 wearing braces or refusing showers. R1's progress note dated November 8, 2023, at 3:52 p.m., documented by Director of Nursing (DON)-A, indicated R1 purchased and applied the knee braces on his own without a doctor's order. R1 refused to have the braces removed because they made him feel better. R1 wore them continually, which caused a large wound inside of the right knee. The wound was discovered on this date because R1 soiled himself and required a bath. On April 2, 2024, at 1:28 p.m., family member (FM)-B stated on the day of the incident, she said	01620		

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01620	Continued From page 7 she was visiting R1 and discovering him unresponsive in his recliner chair. R1 was soiled, and it required the effort of three to four staff members to remove his clothes and transport him to the whirlpool bath. It was during this bath that they first saw the wound. She said she knew R1 had been wearing a brace, as it helped to decrease muscle spasms and pain. On April 9, 2024, at 12:36 p.m., registered nurse (RN)-C stated she was aware of the brace; she had heard about it but had not physically seen it in person. She knew R1 had purchased the brace himself and applied it on his own terms. (RN)-C also said R1 was incontinent, and unlicensed caregivers were expected to check on him at least every shift or whenever he used the call light. She did not remember if unlicensed caregivers had reported to her about the resident refusing showers or care. (RN)-C said that skin assessments were typically conducted during quarterly assessments by the nurse or when the resident had a shower, during which unlicensed caregivers would check the resident's skin and report any issues. She said unlicensed caregivers should notify the nursing team if the resident refused a shower. On April 4, 2024, at 12:01 p.m., PTA-G as R1's mobility gradually declined, causing him to quit walking due to pain, she suggested he try knee braces. R1 purchased them independently four months prior, and she ensured he understood how to properly wear and remove them. PTA-G educated him on not wearing them constantly. She observed him putting on and taking off the braces and noted that the resident found relief from pain while wearing them. She recalled discussing the braces with the nursing staff but could not recall the specific staff member. PTA-G	01620		

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01620	Continued From page 8 said a month before the incident, the resident's mobility significantly declined, and he could no longer be able to stand. PTA-G told the unlicensed caregivers of this decline to prevent staff injury during care. She said the resident complained to her about using the call light without response from staff. She frequently observed he was soiled and had bowel movements on his shoes and clothes. She was not certain if he refused to be cleaned up or if staff neglected to assist him. On her last day working with him, he was very solid, requiring three to four people to assist him into a wheelchair and the bath. When they removed his braces, they discovered the wound, to which the resident seemed unaware. On April 4, 2024, at 10:40 a.m., unlicensed personnel (ULP)-N stated R1 used to walk and often sat in his recliner. She was not sure if he wore braces or not. She said sometimes R1 had bowel movements and attempted to conceal them. If she administered medication and detected an odor, she would then proceed to clean him up. On April 4, 2024, at 2:34 p.m., ULP-I stated she worked mostly the morning shifts and never assisted the resident with dressing. She said she knew about the brace, and R1 managed it independently. However, ULP-I was uncertain whether the nurses were aware of the brace or not. She stated R1 always dressed himself and that the night shift reported he refused care, although he did not refuse for her. On the day R1 was taken to the hospital, the night shift had not changed him, and it required assistance from multiple people to get him up as he could not stand. That week, she found him wet and soiled on several occasions. ULP-I confirmed seeing	01620		

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01620	Continued From page 9 R1's brace only once because staff members were not the ones who put the brace on. On April 4, 2024, at 12:31 p.m., licensed practical nurse (LPN)-R stated she did not recall whether R1 had a brace or not. She said R1 never refused care when she was on duty. LPN-R said she often found R1 soiled and would help him clean up. She said the call lights frequently went unanswered or took a long time. LPN-R confirmed no unlicensed caregivers informed her when R1 refused care and stated unlicensed caregivers were expected to inform the nurse or document it if the resident refused care. If R1 refused a shower, LPN-R said that unlicensed caregivers should at least assist him with bed baths, freshen him up, and provide him with clean clothes. On April 9, 2024, at 4:05 p.m., Director of Nursing (DON)-A stated she found out about the brace when they discovered the wound. She had not been aware of the brace before that time. She said she was informed by physical therapist later that R1 had purchased the brace online himself. The unlicensed caregivers did not report the presence of the brace to her, and she was uncertain whether they had reported it to another nurse. She confirmed the unlicensed caregivers did not inform the nurses about the resident's refusal of the shower. She said she was unable to locate any documentation regarding the shower or the resident's refusal of it. She also said the facility did not conduct skin assessments unless alerted by staff members of a problem. Otherwise, they conducted quarterly general assessments, which R1 had one six months prior. She acknowledged being aware of the resident's declining health. However, she stated the nurse responsible for his care should have conducted	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 10 the change of condition assessment when his care needs transitioned from one person's assistance to two and then to an EZ stand (stand assist lift). The licensee's dated August, 2023 Assessments, Reviews, and Monitoring indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
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 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 and R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred. Regarding HL202579486M and R1 the facility was responsible for the maltreatment, which occurred at the facility. Please refer to the public maltreatment report for details. Regarding HL202572344M and R2 an individual was responsible for the maltreatment, in connection with incidents which occurred at the	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02360	Continued From page 11 facility. Please refer to the public maltreatment report for details.	02360		