Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20381001M
Compliance #: HL20381002C

Date Concluded: September 19, 2022

Name, Address, and County of Licensee Investigated:
Brookdale Edina
3330 Edinborough Way
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Michele R. Larson, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 they failed to reposition the resident every two hours. The resident developed several pressure ulcers on her buttocks and groin area. The resident spent over three months in the hospital due to the pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was unable to reposition herself and required

staff to reposition her every two hours. The facility lacked documentation they repositioned the resident. The resident's wounds and pressure ulcers worsened and developed gangrene. The resident required hospitalization and diagnosed with a large, deep, foul-smelling, pressure ulcer in her tailbone (sacral) area, in addition to several other pressure ulcers. Hospital doctors recommended hospice care to the resident's family member due to the extent of her pressure ulcers (wounds). Staff stated the facility was short-staffed during the time the resident developed the pressure ulcers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The vulnerable adult was interviewed. The investigator interviewed a family member. The investigation included an onsite visit, interviews, and observations of other residents and unlicensed staff. The investigation included review of the resident's facility record, hospital record, photos of the resident's wounds, home health agency records, and wound care notes. The investigator reviewed pertinent facility policy and procedures, staffing schedules, and incident reports.

The resident resided in an assisted living facility and diagnoses included chronic persistent pain and COVID-19. The resident's record indicated she was oriented to person, place, and time. The resident's service plan indicated she received assistance with personal cares, toileting every two to four hours during the day and as needed during the night. The resident also received assistance with transfers, escorts, and medication management. The resident used a mechanical lift for all transfers and a wheelchair for mobility.

The resident's progress notes indicated one day the resident developed shortness of breath and was transferred to a hospital where she was diagnosed with COVID-19. The resident spent one week in the hospital before being discharged back to the facility. The resident was placed on two liters of oxygen via nasal cannula and required a mechanical lift with the assist of two staff persons for all transfers upon her return to the facility. The resident was unable to reposition herself and required staff assistance for all repositioning.

The resident's progress note indicated the resident developed red areas bilaterally on both buttocks and inner thigh areas a few days after she returned to the facility. The resident voiced pain and discomfort during cares. The residents record lacked documentation an assessment was performed by a facility registered nurse (RN) to address a change in skin condition and interventions, such as a repositioning schedule.

The resident's progress note indicated one week later the resident developed an open wound on her left groin. The resident's progress note indicated three weeks after being discharged from the hospital, the resident had four open pressure ulcers on her right and left buttocks. Barrier ointment was applied around the open sores. Orders were sent to the resident's physician for home health wound care.

The resident's record lacked documentation staff were retrained on repositioning the resident, and a RN assessment.

The resident's progress note indicated the next day a physical therapist (PT) found a 50-cent size black pressure sore on the resident's left heel after she complained of heel pain. The note indicated an order for home health wound care was obtained. The resident's skin near her tailbone and inner thighs was open, red, raw, and bleeding.

The resident's home health note indicated two days later, a home health wound care RN cleaned and dressed the resident's open sores. The wound care RN measured four open sores in her groin and buttocks; inner thigh- 2 centimeters (cm) x 0.4 cmx 0.01 cm; right buttock- 4.2 cm x 2 cm x 0.01 cm; left buttock 1 cm x 0.7 cm x 0.01 cm. Wound care was ordered for Monday, Wednesday, and Friday. The wound care RN educated staff to keep the resident's sores clean and dry and to reposition the resident.

The resident's record lacked a facility RN assessment addressing the residents wounds and changes in care needs.

The resident's home health note indicated the home health RN performed wound care to the resident's left heel and buttocks. The home health RN communicated to facility staff, "needs to be up in chair more. Check, change, reposition in bed every two hours."

The resident's record lacked a RN assessment of the residents change in status or addressing the home health RN's recommended care changes with mobility, toileting and repositioning.

The resident's home health RN note indicated weeks after the resident's first known skin breakdown, the home health RN found the resident incontinent of urine and feces. The resident's open sores were soaked in her urine and feces. The RN did not know how long the resident sat in her soiled brief. The home health note indicated the resident's open sores appeared to be infected. Emergency medical services (EMS) was called to transport the resident to the hospital.

The resident's hospital record indicated the resident arrived at the hospital with nine open wounds, pressure sores. The size of her sacral (tailbone) pressure ulcer was measured from a size of 4 cm x 3 cm x 2 cm to a size of 40 cm x 12 cm x 4 cm that tunneled down to the deeper level of her connective tissue (fascia). The hospital record indicated facility nurses stated the resident's wounds looked "much worse" than before. The wounds were raw, with skin breakdown. Wounds on the resident's one buttock and tailbone were dark black. The resident's pressure sores were foul-smelling, and the skin surrounding her open pressure ulcers was necrotic (dead), with undermining (tunneling) noted beneath the surface. The doctor was unable to visualize the resident's entire pressure ulcer due to the depth of her wounds. Surgery was performed to debride and irrigate her pressure sores. The resident's prognosis remained guarded.

The resident remained hospitalized for over three months due to the extent of her pressure ulcers.

During the investigator's onsite visit, an unlicensed staff person stated the facility was short-staffed, stating, "It's stressful and tiring. It's been that way for a while."

During an interview, a home health wound care nurse stated she educated facility nurses on repositioning the resident every two hours but stated the facility did not have enough staff. The home health nurse stated the resident was not repositioned stating she always found the resident lying "flat on her back" with no pillows. The home health nurse stated, "one time I found her flat on her back with the thermostat set at 90 degrees with three blankets, lying in urine and feces." The home health nurse stated the resident was prescribed a diuretic pill and needed to be changed often but stated the resident was always incontinent of urine and feces during each home health visit. The home health wound care nurse stated it was an outside agency unlicensed staff person who alerted her about the resident's pressure sores.

During an interview, a facility nurse stated the resident was unable to assist during cares or repositioning, but still "encouraged" the resident to change positions from her bed to a chair. The nurse stated although the facility did not provide wound care, they had their RN's "shadow" the home health wound care nurse so they could lay eyes on the resident's wounds. The nurse stated she was unsure the resident had a toileting schedule, and stated unlicensed staff only documented they performed toileting service for the day but did not document the number of times they toileted the resident. The nurse stated it was the facility's responsibility to ensure the resident was repositioned and kept the wounds clean and dry.

During an interview, an unlicensed staff person stated the resident required assistance with repositioning after she got COVID-19 and stated they "thought" the resident had a repositioning schedule, stating, "it's in her service plan." The unlicensed staff person stated they performed simple wound cares for residents and stated if a resident who received wound care had a soiled dressing, they changed their dressings too if they had instructions from a facility nurse. The unlicensed staff person stated they also changed dressings over pressure sores that had urine or feces on them from sitting or lying down. The unlicensed staff person stated staff ratios varied from day-to day stating, "we were short-staffed, but right now we are okay."

During interviews, multiple staff stated the facility was short-staffed.

During an interview, the resident stated she recalled waiting a long time for staff to answer her call light when she had to use the bathroom, stating, "I would be wet for a while." The resident stated, "they delivered food and they were gone. I was supposed to be turned but they didn't do it." The resident stated she recalled staff telling her the facility was short-staffed. The

resident stated she felt the facility did not care about her because no one would come when she rang her call light, stating she felt scared when she was not taken care of.

During an interview, a family member stated she performed a brief count and realized the facility changed the resident's briefs 17 times during a two-week period. The family member stated the resident told her she could feel the urine soaking her back when she was lying in her bed. The family member stated she showed the resident's pressure sores to two facility nurses two weeks before the resident was transported to a hospital but stated they did nothing. The family member stated on weekends the facility sometimes had two staff working three floors per shift, stating the resident required the assist of two staff using the mechanical lift. The family member stated one pressure ulcer was "green and pussy" the day the resident was sent to the hospital. The family member stated the hospital doctor told her the infection had gone into the resident's bone, stating the doctors had to "scrape" off the necrotic bone.

In conclusion, the Minnesota Department of Health determined 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:
(a) 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 called 911 to obtain emergency services for the resident.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 06/09/2022

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL20381004C/HL20381003M & HL20381002C/HL20381001M On June 9, 2022, 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 72 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued that were not issued at the time of immediate correction orders. The following correction orders are issued for HL20381002C/001M 620, 630 1620, 2360 and 3000. The following correction order is issued for HL20381004C/003M, tag identification 630.	0 000	Minnesota Department of Health is documenting the State Licensing 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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0 000	Continued From page 1 Immediate order, tag 510 was corrected on June 9, 2022.	0 000		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. This had the potential to affect all 153 residents residing in the licensee's building. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510	Immediacy of correction order lifted and order corrected as of 2:30pm, June 9, 2022, no further action required.	

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0 510	Continued From page 2 The findings include: PERSONAL PROTECTIVE EQUIPMENT (PPE) The licensee failed to ensure staff followed proper COVID-19 infection control practices as recommended by the Centers for Disease Control (CDC) and the Minnesota Department of Health (MDH). The CDC undated guidance titled, Use PPE When Caring for Patients with Confirmed or Suspected COVID-19, indicated healthcare personnel (HCP) must remove gloves and gown before exiting a COVID-19 positive room. On June 9, 2022, at 12:13 p.m., MDH issued an immediate correction order to the licensee due to the licensee failing to ensure staff were properly trained on donning and doffing PPE when entering COVID-19 positive rooms. On June 9, 2022, at 9:07 a.m., the surveyor entered the facility. At 9:35 a.m., an entrance conference was initiated with the executive director (ED)-A, the director of nursing (DON)-B, and the assistance executive director (AED)-C. ED-A stated out of the 153 residents residing in the facility, 72 received assisted living services. During the entrance conference, ED-A stated the facility had COVID-19 positive residents and staff. ED-A stated the COVID-19 positive residents resided in memory care and assisted living. On June 9, 2022, at 9:55 a.m., the surveyor toured the facility with AED-C. At 10:00 a.m., AED-C and the surveyor entered the third floor memory care. In the hallway between two COVID-19 positive rooms, the investigator observed a trash bin filled with soiled gowns that were worn by staff entering COVID-19 rooms.	0 510		

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0 510	Continued From page 3 Unlicensed personnel (ULP)-D stated, "we were told to put the bin out in the hallway." On June 9, 2022, at 10:07 a.m., housekeeper (HK)-E was observed donning a gown outside a COVID-19 positive resident's room. The door to the resident's room was wide open. HK-E entered the resident's room and began cleaning, but did not shut the door The surveyor requested AED-C to close the resident's door. On June 9, 2022, at 10:13 a.m., HK-E was observed walking out of the COVID-19 positive room wearing the gown and gloves she wore while inside the COVID-19 positive room. HK-E continued to walk down the hall wearing the contaminated PPE. On June 9, 2022, at 10:16 a.m., HK-F was observed walking out of a COVID-19 room wearing contaminated PPE. On June 9, 2022, at 10:31 a.m., DON-B stated their district director registered nurse (RN) was responsible for ensuring staff were trained on COVID-19 infection control and PPE. The surveyor requested the facility's COVID-19 infection control policy. On June 9, 2022, at 11:40 a.m., ULP-D and ULP-G were unable to state the correct order for donning and doffing PPE when entering and leaving COVID-19 positive rooms. On June 9, 2022, at 1:54 p.m., ED-A provided the COVID-19 policy. The licensee policy titled, Minnesota Infection Prevention and Control Plan, dated August 2021, indicated, staff should wear PPE (gloves, gowns,	0 510		

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0 510	Continued From page 4 mouth, nose and eye protection as indicated by the potential for contact with blood or body fluids. Gowns should be worn to protect skin and clothing from contamination from secretions of bodily fluids, excretions, or blood. Gowns were not to be reused and were to be removed prior to leaving the resident's room. TIME PERIOD TO CORRECT: IMMEDIATE On June 9, 2022, at 2:30 p.m. the immediacy of the correction order was lifted and the order corrected when ED-A provided the surveyor with the facility's plan of correction (POC). All facility staff were retrained and were required to demonstrate competency for donning and doffing of PPE when entering isolation rooms. Staff signed the forms stating they were retrained and understood the training.	0 510		
0 620 SS=G	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center	0 620		

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0 620	Continued From page 5 (MAARC) for one of two resident's (R1) with records reviewed. R1 developed extensive pressure ulcers on her buttocks, groin, and tailbone areas. R1 admitted to the hospital and stayed for over three months after she had developed extensive pressure ulcers on her buttocks and groin area at the licensee. One of her pressure ulcers developed gangrene. 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 a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1's medical record was reviewed. R1 admitted to the facility on May 26, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included chronic pain syndrome and COVID-19. R1's service plan dated December 10, 2021, indicated R1 received assistance with personal cares, chronic condition management, medication management, respiratory equipment, toileting, escorts, and coordination of services. R1's service plan indicated R1 required assistance with toileting and transferring to the bathroom every two to four hours during the day and as needed (PRN) at night with the assist of two staff using a Hoyer lift (total body mechanical lift). R1 used a Hoyer lift for all transfers and a wheelchair for mobility.	0 620		

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0 620	Continued From page 6 R1's service delivery record was requested but not provided. R1's individual abuse prevention plan (IAPP) dated December 12, 2021, indicated R1 had difficulty reporting abuse and was susceptible to being abused by others. R1's assessment dated December 10, 2021, indicated R1 needed assistance in getting to and from the bathroom and help getting on and off the toilet seat. R1 was assessed as having no wounds. R1's home health wound care note dated January 10, 2022, and written by registered nurse (RN)-I, indicated R1 had four wounds on her body; left shin 1.5 centimeters (cm) x 0.8 cm x 0.01 cm; left inner thigh- 2 cm x 0.4 cm x 0.1 cm; right buttock- 4.2 cm x 2.0 cm x 0.01 cm; left buttock- 1.0 cm x 0.7 cm x 0.01 cm. RN-I indicated wound care was ordered three times per week (Monday, Wednesday, Friday) until R1's wounds healed. RN-I educated facility staff on repositioning and keeping her wounds clean and dry. R1's Braden skin assessment dated January 21, 2022, indicated R1 was assessed as having redness on her groin and buttocks area, and a purple area on her inner thigh. R1 had slightly limited in her sensory perception, very moist, charifast, limited mobility, and with a potential problem with friction and shear. R1's score was 14. A Braden score of 16 or less required prevention strategies. R1's home health wound care note dated January 14, 2022, indicated RN-I cleaned and dressed R1's left heel pressure sore. A pressure relief	0 620		

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0 620	Continued From page 7 heel protector boot was applied to R1's left foot. R1's home health note indicated RN-I educated facility staff. RN-I indicated, "R1 needs to be up in chair more. Check, change, reposition in bed every two hours." R1's home health wound care note dated January 17, 2022, indicated R1 was incontinent of urine and feces. RN-I observed R1's dressings were saturated with urine. RN-I observed R1's skin surround her wounds was breaking down (macerated) from being in contact too long with moisture from the urine and feces. R1's home health wound care note dated January 26, 2022, indicated RN-I gave instructions to facility staff to place pillows on R1's right side to "off-load the pressure on wound on R1's right buttock. The note indicated RN-I educated staff to shift R1's weight from side-to-side. R1's home health wound care note dated January 31, 2022, indicated R1 had the following pressure ulcers (wounds): (1) on left heel- 21 cm x 1.0 cm x 0.01 cm; (1) right buttock- 7.2 cm x 6.4 cm x 0.5 cm; left buttock (2) 1.0 cm x 0.3 cm x 0.02 cm and 0.5 cm x 0.5 cm x 0.01 cm; coccyx (tailbone)- 5.0 cm x 2.6 cm x 0.2 cm. RN-I educated staff on repositioning R1. R1's home health wound care notes dated February 2, 2022, indicated an RN from the home health agency assessed R1's wounds as possibly infected. R1 was found incontinent of urine and feces. The notes indicated it was unclear how long R1 sat wearing her soiled brief. Emergency medical services (EMS) was called. R1's hospital record indicated on February 2, 2022, at 5:23 p.m., R1 was transported to a	0 620		

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0 620	Continued From page 8 hospital with extensive pressure ulcers on her buttocks, groin, and coccyx areas. The record indicated R1 had a large, deep foul-smelling wound in the base of her lower spine/tailbone area. Some of R1's pressure ulcers (wounds) were noted to be necrotic and unstageable with "significant" undermining (tunneling) around the wound edges. R1's prognosis for wound healing was guarded. R1's record lacked evidence a Minnesota Adult Abuse Reporting Center (MAARC) report was filed by the facility. On June 16, 2022, at 10:15 a.m., executive director (ED)-A stated the facility had staffing struggles but never fell below safety standards. ED-A stated R1 received safety checks. ED-A stated she "thought" the safety checks were listed in her service plan. Ed-A stated staff performed safety checks when they performed cares for R1. ED-A stated R1 was unable to assist with transferring herself and required at least two staff for repositioning and transfers. ED-A stated the facility sent R1 to the hospital after it was identified R1's wounds had increased. The licensee policy titled Abuse, Neglect, and Exploitation, updated August 2021, indicated the executive director would file a report with the Common Entry Point (CEP) if determined or reason to believe a resident was abused, neglected, exploited, or had a physical injury that could not be reasonably explained. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 9 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and update individual abuse prevention plans (IAPP) that addressed assessed areas of potential abuse and implement specific interventions to reduce the risk of abuse for two of two residents (R1, R2) with records reviewed. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's medical record was reviewed. R1 admitted to the facility on May 26, 2021, under the	0 630		

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0 630	Continued From page 10 comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included chronic pain syndrome and COVID-19. R1's assessment dated December 10, 2021, indicated R1 needed assistance in getting to and from the bathroom and help getting on and off the toilet seat. R1 was assessed as having no wounds. R1's service plan dated December 15, 2021, indicated R1 received daily assistance with personal cares, toileting, medication management, respiratory equipment, escorts, and coordination of services; and weekly assistance with laundry and housekeeping. R1's service plan indicated R1 was to receive assistance with toileting and transferring to the bathroom every two to four hours during the day and as needed (PRN) at night (HS) with the assist of two staff using a Hoyer lift. R1 used a Hoyer lift for all transfers and a wheelchair for mobility. R1's IAPP dated December 15, 2021, indicated R1 was assessed as having difficulty reporting abuse and was susceptible to being abused by others with a listed intervention of staff were trained in abuse signs and symptoms and immediately report signs of abuse to their supervisors. R1's progress note dated December 29, 2021, at 2:24 p.m., indicated R1 had four open pressure sores on her right and left buttocks. Cleanser and foam dressing were applied to the pressure sores. Orders were sent to R1's physician for home health wound care.	0 630		

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0 630	Continued From page 11 R1's Braden skin assessment dated January 21, 2022, indicated R1 was assessed as being slightly limited in her sensory perception, very moist, charifast, limited mobility, and with a potential problem with friction and shear. R1's IAPP lacked evidence it was updated after R1 developed her extensive pressure sores. R1's IAPP lacked specific interventions addressing R1's assessed vulnerabilities. R2 R2's medical record was reviewed. R2 admitted to the facility on October 28, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2 was discharged from the facility on March 22, 2022. R2's diagnoses included dementia without behavioral disturbance. R2's service plan dated October 7, 2021, indicated R2 received daily assistance with personal cares, toileting, and medication management; and weekly assistance with housekeeping, and laundry. R2 used a two-wheeled walker for walking, and a wheelchair for long distances. R2's IAPP dated October 28, 2020, indicated R2 was assessed as exhibited cognitive impairment or memory loss with a listed intervention of had a history of falls. R2 was vulnerable to being unable to evacuate self in an emergency with a listed intervention of "see personal service plan (PSP)." R2 was vulnerable to being unable to keep a clean and safe environment with a listed intervention of "see PSP." R2 was vulnerable to being unable to manager finances with a listed intervention of, "see PSP."	0 630		

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0 630	Continued From page 12 R2's IAPP lacked specific interventions addressing R2's assessed vulnerabilities. R2's assessment dated January 5, 2022, indicated R2 had difficulty with being oriented to person, place, and time. On June 27, 2022, at 3:22 p.m., registered nurse (RN)-J stated IAPPs were revised every 90-days or when residents experienced a change in condition. The licensee policy titled Individual Abuse Prevention Plan (IAPP), updated August 2021, indicated areas of concern would be addressed in the resident's service plan and individualized for each resident with problematic areas, outcomes with documented resolution. Resident's vulnerability stated would be reassessed annually and reviewed with significant changes as needed. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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	01620		

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01620	Continued From page 13 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 ensure a registered nurse (RN) performed a reassessment for one of two residents (R1) with records reviewed. R1 developed several pressure sores (ulcers) on her buttocks, groin, and tailbone areas but was not reassessed. 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 a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1's medical record was reviewed. R1 admitted to the facility on May 26, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses included chronic pain syndrome and COVID-19.	01620		

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01620	Continued From page 14 R1's service plan dated December 10, 2021, indicated R1 received assistance with personal cares, chronic condition management, medication management, respiratory equipment, toileting, escorts, and coordination of services. R1's service plan indicated R1 required assistance with toileting and transferring to the bathroom every two to four hours during the day and as needed (PRN) at night with the assist of two staff using a Hoyer lift (total body mechanical lift). R1 used a Hoyer lift for all transfers and a wheelchair for mobility. R1's assessment dated December 10, 2021, indicated R1 needed assistance in getting to and from the bathroom and help getting on and off the toilet seat. R1 was assessed as having no wounds. R1's progress note dated December 29, 2021, at 2:24 p.m., indicated R1 had four open pressure sores on her right and left buttocks. Cleanser and foam dressing were applied to the pressure sores. Orders were sent to R1's physician for home health wound care. R1's record lacked further assessment R1's mobility after developing pressure ulcers or an assessment identifying if any changes in services were required. R1's home health wound care note dated January 10, 2022, and written by RN-I, indicated R1 had four wounds on her body; left shin 1.5 centimeters (cm) x 0.8 cm x 0.01 cm; left inner thigh- 2 cm x 0.4 cm x 0.1 cm; right buttock- 4.2 cm x 2.0 cm x 0.01 cm; left buttock- 1.0 cm x 0.7 cm x 0.01 cm. RN-I indicated wound care was ordered three times per week (Monday,	01620		

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01620	Continued From page 15 Wednesday, Friday) until R1's wounds healed. RN-I educated facility staff on repositioning and keeping her wounds clean and dry. R1's facility record lacked an assessment of R1 after the developement of wounds and pressure ulcers. R1's Braden skin assessment dated January 21, 2022, indicated R1 was assessed as having redness on her groin and buttocks area, and a purple area on her inner thigh. R1 had slightly limited in her sensory perception, very moist, charifast, limited mobility, and with a potential problem with friction and shear. R1's score was 14. A Braden score of 16 or less required prevention strategies. R1's record lacked interventions to prevent additional skin breakdown. R1's home health wound care note dated January 14, 2022, indicated RN-I cleaned and dressed R1's left heel pressure sore. A pressure relief heel protector boot was applied to R1's left foot. R1's home health note indicated RN-I educated facility staff. RN-I indicated, "R1 needs to be up in chair more. Check, change, reposition in bed every two hours." R1's record lacked an assessment after R1 developed a new left heel pressure sore. R1's home health wound care note dated January 17, 2022, indicated R1 was incontinent of urine and feces. RN-I observed R1's dressings were saturated with urine. RN-I observed R1's skin surround her wounds was breaking down (macerated) from being in contact too long with moisture from the urine and feces.	01620		

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01620	Continued From page 16 R1's home health wound care note dated January 26, 2022, indicated RN-I gave instructions to facility staff to place pillows on R1's right side to "off-load the pressure on wound on R1's right buttock. The note indicated RN-I educated staff to shift R1's weight from side-to-side. R1's record lacked an assessment of R1 after home health had indicated the need for additional cares and services. R1's home health wound care note dated January 31, 2022, indicated R1 had the following pressure ulcers (wounds): (1) on left heel- 21 cm x 1.0 cm x 0.01 cm; (1) right buttock- 7.2 cm x 6.4 cm x 0.5 cm; left buttock (2) 1.0 cm x 0.3 cm x 0.02 cm and 0.5 cm x 0.5 cm x 0.01 cm; coccyx (tailbone)- 5.0 cm x 2.6 cm x 0.2 cm. RN-I educated staff on repositioning R1. R1's record lacked an assessment of R1 due to worsening wound conditions with wounds increasing in size and depth. R1's hospital record indicated on February 2, 2022, at 5:23 p.m., R1 was transported to a hospital with extensive pressure ulcers on her buttocks, groin, and coccyx areas. The record indicated R1 had a large, deep foul-smelling wound in the base of her lower spine/tailbone area. Some of R1's pressure ulcers (wounds) were noted to be necrotic and unstageable with "significant" undermining (tunneling) around the wound edges. R1's prognosis for wound healing was guarded. R1's doctors recommended hospice care due to the extent of her pressure wounds. R1's record lacked evidence R1 was reassessed	01620		

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01620	Continued From page 17 by a facility RN after she developed the pressure sores. On June 27, 2022, at 3:22 p.m., RN-J stated assessments were performed whenever a resident experienced a change-in-condition. The licensee policy titled, Change of Condition, updated February 2021, indicated a change of condition should be evaluated and documented for residents who exhibited significant deviation in physical or mental status. 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: Based on observations, interviews, and document review, the facility failed to ensure one of two residents (R1) reviewed was free from maltreatment. R1 was neglected. Findings include: On September 19, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	Plan of correction is not required for tag 2360. Please refer to the public maltreatment report for details.	

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03000 SS=G	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,	03000		

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03000	Continued From page 19 subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of two resident's (R1) with records reviewed. R1 developed extensive pressure ulcers on her buttocks, groin, and tailbone areas. R1 admitted to the hospital and stayed for over three months after she had developed extensive pressure ulcers on her buttocks and groin area at the licensee. One of her pressure ulcers developed gangrene. 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 a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1's medical record was reviewed. R1 admitted to the facility on May 26, 2021, under the comprehensive home care license and began receiving assisted living services on August 1,	03000		

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03000	Continued From page 20 2021. R1's diagnoses included chronic pain syndrome and COVID-19. R1's service plan dated December 10, 2021, indicated R1 received assistance with personal cares, chronic condition management, medication management, respiratory equipment, toileting, escorts, and coordination of services. R1's service plan indicated R1 required assistance with toileting and transferring to the bathroom every two to four hours during the day and as needed (PRN) at night with the assist of two staff using a Hoyer lift (total body mechanical lift). R1 used a Hoyer lift for all transfers and a wheelchair for mobility. R1's service delivery record was requested but not provided. R1's individual abuse prevention plan (IAPP) dated December 12, 2021, indicated R1 had difficulty reporting abuse and was susceptible to being abused by others. R1's assessment dated December 10, 2021, indicated R1 needed assistance in getting to and from the bathroom and help getting on and off the toilet seat. R1 was assessed as having no wounds. R1's home health wound care note dated January 10, 2022, and written by registered nurse (RN)-I, indicated R1 had four wounds on her body; left shin 1.5 centimeters (cm) x 0.8 cm x 0.01 cm; left inner thigh- 2 cm x 0.4 cm x 0.1 cm; right buttock- 4.2 cm x 2.0 cm x 0.01 cm; left buttock- 1.0 cm x 0.7 cm x 0.01 cm. RN-I indicated wound care was ordered three times per week (Monday, Wednesday, Friday) until R1's wounds healed. RN-I educated facility staff on repositioning and	03000		

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03000	Continued From page 21 keeping her wounds clean and dry. R1's Braden skin assessment dated January 21, 2022, indicated R1 was assessed as having redness on her groin and buttocks area, and a purple area on her inner thigh. R1 had slightly limited in her sensory perception, very moist, charifast, limited mobility, and with a potential problem with friction and shear. R1's score was 14. A Braden score of 16 or less required prevention strategies. R1's home health wound care note dated January 14, 2022, indicated RN-I cleaned and dressed R1's left heel pressure sore. A pressure relief heel protector boot was applied to R1's left foot. R1's home health note indicated RN-I educated facility staff. RN-I indicated, "R1 needs to be up in chair more. Check, change, reposition in bed every two hours." R1's home health wound care note dated January 17, 2022, indicated R1 was incontinent of urine and feces. RN-I observed R1's dressings were saturated with urine. RN-I observed R1's skin surround her wounds was breaking down (macerated) from being in contact too long with moisture from the urine and feces. R1's home health wound care note dated January 26, 2022, indicated RN-I gave instructions to facility staff to place pillows on R1's right side to "off-load the pressure on wound on R1's right buttock. The note indicated RN-I educated staff to shift R1's weight from side-to-side. R1's home health wound care note dated January 31, 2022, indicated R1 had the following pressure ulcers (wounds): (1) on left heel- 2.1 cm x 1.0 cm x 0.01 cm; (1) right buttock- 7.2 cm x 6.4 cm x 0.5	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 22 cm; left buttock (2) 1.0 cm x 0.3 cm x 0.02 cm and 0.5 cm x 0.5 cm x 0.01 cm; coccyx (tailbone)-5.0 cm x 2.6 cm x 0.2 cm. RN-I educated staff on repositioning R1. R1's home health wound care notes dated February 2, 2022, indicated an RN from the home health agency assessed R1's wounds as possibly infected. R1 was found incontinent of urine and feces. The notes indicated it was unclear how long R1 sat wearing her soiled brief. Emergency medical services (EMS) was called. R1's hospital record indicated on February 2, 2022, at 5:23 p.m., R1 was transported to a hospital with extensive pressure ulcers on her buttocks, groin, and coccyx areas. The record indicated R1 had a large, deep foul-smelling wound in the base of her lower spine/tailbone area. Some of R1's pressure ulcers (wounds) were noted to be necrotic and unstageable with "significant" undermining (tunneling) around the wound edges. R1's prognosis for wound healing was guarded. R1's record lacked evidence a Minnesota Adult Abuse Reporting Center (MAARC) report was filed by the facility. On June 16, 2022, at 10:15 a.m., executive director (ED)-A stated the facility had staffing struggles but never fell below safety standards. ED-A stated R1 received safety checks. ED-A stated she "thought" the safety checks were listed in her service plan. Ed-A stated staff performed safety checks when they performed cares for R1. ED-A stated R1 was unable to assist with transferring herself and required at least two staff for repositioning and transfers. ED-A stated the facility sent R1 to the hospital after it was	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 23 identified R1's wounds had increased. The licensee policy titled Abuse, Neglect, and Exploitation, updated August 2021, indicated the executive director would file a report with the Common Entry Point (CEP) if determined or reason to believe a resident was abused, neglected, exploited, or had a physical injury that could not be reasonably explained. TIME PERIOD TO CORRECT: Seven (7) days.	03000		