Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203812800M
Compliance #: HL203812344C

Date Concluded: April 29, 2024

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

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

Evaluator's Name: Peggy L Boeck, 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 a resident when they failed to ensure nursing follow-up when staff reported the resident skin issues. Several weeks later, the resident was sent to the hospital and had her toe amputated due to infection in the bone.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Staff reported their observations of the resident's toe wound to several facility nurses, however, nursing failed to followed-up with assessments or notification to the resident's primary care provider. The resident's toe infection infiltrated the bone and up the resident's leg. The resident required hospitalization and surgery to amputate the toe. The hospital staff discovered an additional open wound on the resident's upper arm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included

review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures.

The resident lived in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, and osteoporosis. The resident's assessment indicated she required assistance with grooming, dressing, twice weekly showers, and used a walker for mobility.

An incident report indicated a staff noticed a bump on the resident's toe after a bath. The staff notified an administrative nurse per facility protocol. The administrative nurse failed to assess the resident's toe. The report indicated one week later a staff notified the administrative nurse that the resident's toe wound worsened. Another nurse assessed the wound. Neither nurse notified the primary care provider nor changed the services to include wound care. Several days later another staff notified a third nurse, who sent the primary care provider a message via electronic portal. The following day the provider indicated in a return message the provider would assess the resident on her next visit. The report indicated the provider saw the resident's toe two days later, ordered an x-ray, and an antibiotic. The report indicated administration decided to send the resident to the emergency department.

Hospital records indicated the resident presented to the emergency department with a necrotic (dead tissue) infection with an abscess (a mass filled with pus) on her toe. The records indicated X-rays identified the infection infiltrated the bone and the doctors had to amputate the resident's toe. The record indicated during examination, the hospital identified and treated an open, draining wound on the resident's upper arm. The resident discharged from the hospital 12 days later with orders for wound cares and required a wheelchair for mobility.

During an interview, the administrative nurse stated the facility protocol directed staff to notify nursing of changes in resident's condition, including skin issues. The administrative nurse stated the facility policies did not require the staff to document the communication. The administrative nurse stated she was new and busy (as the only nurse in the building with over 80 residents). The administrative nurse stated when the staff told her about the resident's toe, she was too busy and did not assess the wound. The administrative nurse stated the following week staff told her the wound was getting worse, so she delegated another nurse to assess the resident. The administrative nurse stated she did not follow-up on whether the nurse completed the assessment, notified the provider, or changed the services.

During an interview a nurse stated she went to the facility to help the administrative nurse, who was new and busy. The nurse stated she completed the task of assessing the resident's foot, cleaning the area, and placing a bandage on it. The nurse stated she put a note in the facility skin management record and believed that the administrative nurse would follow-up with the provider and change the resident's services.

During investigative interviews, multiple staff members stated they viewed the resident's wound on her toe and notified nursing several times. The staff members stated they reported

to the nurse and provided photos of the wound on several occasions a month prior to the resident's hospitalization, but there was no nursing follow-up.

During an interview, a family member stated they had difficulty understanding how the facility nurse saw a wound on the resident's toe and a week later decided to send her to the hospital.

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 moved to a different facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reported they initiated new skin assessments of all residents, provided training to all nurses on the facility skin assessment procedure, training to unlicensed staff, and corrective action to nurses involved.

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
Edina City Attorney
Edina Police Department

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 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDINA	3330 EDINBOROUGH WAY EDINA, MN 55435

(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: #HL203812344C/ #HL203812800M On April 16, 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 58 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL203812344C/ #HL203812800M, tag identification 2310, 2360.	0 000		
02310 SS=K	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 1 standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services for one of one resident (R1) reviewed for pressure ulcers. The licensee failed to have a system in place to ensure nursing followed up on changes in the condition of R1's skin when several unlicensed staff notified nursing, three times in two weeks, of a wound on R1's lower extremity. Harm occurred when R1 developed an infection infiltrating bone, which required amputation of R1's toe. The lack of systems had the potential to affect all residents receiving services from the licensee. This practice resulted in a level four violation (a violation that results in 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). Findings include: R1 moved into the facility on April 24, 2020. R1 resided on a memory care unit due to diagnoses that included dementia, anxiety, and osteoporosis. R1's nursing assessment dated March 14, 2024, indicated R1 received services including staff assistance with grooming, dressing (including putting on/taking off socks and shoes), and showering (including staff washing lower body) twice weekly (Tuesday and Friday between 11:00 a.m. and 12:00 p.m.). R1's assessment indicated	02310	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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02310	Continued From page 2 R1 used a walker for mobility. R1's assessment indicated R1 had a 1 centimeter (cm) by 1 cm by 0.1 cm wound on the second toe of her left foot covered by a band aide. R1's progress note dated March 15, 2024, at 11:45 p.m. indicated licensed practical nurse (LPN)-E sent a message to R1's primary care provider through the Bluestone portal (electronic messaging system) that indicated R1 needed to be seen "for left lower leg" which was "swollen, has a shinny [sic] appearance and is warm to the touch". R1's progress note dated March 17, 2024 at 4:50 p.m. indicated R1's primary care provider would, "Make sure she is on our schedule". R1's progress note dated March 18, 2024, at 3:36 p.m. indicated R1's primary care provider observed the wound (on March 18, 2024) and due to progression of wound since assessed on March 11, 2024, R1 was sent for evaluation at the emergency department. R1's hospital record dated March 18, 2024, indicated R1 presented to the emergency department with a necrotic soft tissue infection with an abscess on the second toe of her left foot. R1's record indicated the hospital admitted R1 due to diagnosis of osteomyelitis (bone infection) with swelling and redness up her left ankle. R1 received intravenous (IV) antibiotics. The x-rays identified erosive changes to the bone and the doctors amputated R1's left second toe. During examination the hospital also identified, photographed, and treated an open, draining wound on R1's left upper arm measuring 2 cm (length) by 1.5 cm (width) by 0.1 cm (deep). R1 discharged from the hospital 12 days later with	02310		

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02310	Continued From page 3 orders for daily wound cares and a wheelchair for mobility. During an interview on April 16, 2024, at 9:07 a.m. unlicensed personnel (ULP)-A stated he noticed R1's second toe on her left foot had swelling and a bump on it in February, 2024. ULP-A stated on February 27, 2024, he noticed it looked infected with pus coming out, so he took a photo and showed it to a nurse. ULP-A did not recall which nurse he reported the information to. ULP-A stated he and other staff notified nursing three or four times including when he shared a photo with a nurse on March 7, 2024. (ULP-A shared the photos with the investigator). During an interview on April 16, 2024, at 9:36 a.m. (former interim Health and Wellness Director) Registered Nurse (RN)-B stated she was asked to come to the facility to help the new health and wellness director (HWD)- D. RN-B stated HWD-D directed her on an unknown date to look at R1's skin. RN-B stated she assessed R1's toe, cleaned it, and bandaged it. HWD-B stated she thought HWD-D would follow-up with notification to R1's doctor and make required changes to R1's service plan. RN-B stated the facility protocol directed staff to report skin concerns to nursing. RN-B stated the facility did not require staff documentation of reports to nursing. RN-B stated when R1 returned from the hospital she required a wheelchair for mobility. During an interview on April 16, 2024, at 10:00 a.m. ULP-C stated she observed R1's toe skin changes in early March, 2024. ULP-C stated the facility protocol directed staff to report to nursing and, "they [nursing] take care of it". ULP-C stated the information did not get into the resident's medical record unless the nurse wrote a progress	02310		

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02310	Continued From page 4 note. ULP-C stated there was lack of communication between staff who provided care and management (including nurses). ULP-C stated she received training on use of, "skin report cards" for skin checks, but staff did not use them. ULP-C stated she took photos of R1's legs on March 11, 2024, and shared with a nurse (HWD-D). (ULP-C shared the photos with the investigator.) During an interview on April 16, 2024, at 10:35 a.m. the former HWD-D stated the facility had several documentation systems that were not coordinated (Point Click Care electronic health record, a wound tracking system, and staff handwritten shift reports) so information needed to be entered into each system separately, which did not always happen. HWD-D stated she recalled a ULP telling her of an open area on R1's toe so she delegated a wound assessment to RN-B. HWD-D stated RN-B failed to notify R1's primary care provider or create a wound care plan. HWD-D stated she did not follow-up or check to see if RN-B completed the required tasks because RN-B was a registered nurse with the same training as herself. The Change of Condition policy dated February 2021, indicated a resident change of condition should be evaluated and documented for residents who exhibit significant deviation in physical or mental status. The policy required an update to the resident's record and service plan. The Abuse, Neglect, and Exploitation policy dated August 2021, defined neglect as the failure or omission by a caregiver to supply a vulnerable adult with care or services reasonable and necessary to obtain or maintain the resident's physical/mental health and safety.	02310		

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02310	Continued From page 5 The Skin Integrity Documentation policy dated May 2023, indicated caregivers should report skin changes. The policy indicated the health and wellness director (HWD) should review the "skin report card", take appropriate action, and follow the change of condition policy. The Open Area Documentation policy dated April 2024, indicated residents with open areas should have regular documentation of the status of those areas by a nurse regardless of third-party involvement. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 6 No plan of correction is required for this tag.	02360		