DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL211297186M
Compliance #: HL211293520C

Date Concluded: March 28, 2024

Name, Address, and County of Licensee Investigated:
Abilit Holdings Meadow Lakes
535 Canyon Dr NW
Eyota, MN 55934
Olmstead County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident had skin breakdown requiring hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident developed further skin concerns requiring hospitalization, the resident made his own health decisions and refused services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the vulnerable adult. The investigation included a review of plan of care, progress notes, assessments, and hospital documents. Also, the investigator observed interactions between staff members and residents during a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included edema, lymphedema (swelling), and hypertension (high blood pressure). The resident's service plan indicated the resident was independent with walking, dressing, grooming, toileting and managed his own medications. The service plan indicated resident required assistance once a week for showering at which time skin was checked with any changes reported to the nurse.

The progress notes indicated the resident required two separate hospitalizations within approximately two weeks.

The facility progress notes indicated, or the first hospitalization occurred after he went to a clinic for wound care, and it was determined he required hospitalization.

During the first hospitalization the hospital records indicated the resident had poorly healing wounds to bilateral lower legs and feet with pseudomonas (type of bacteria) infection. During this hospitalization he received intravenous antibiotics and was discharged back to the facility with an order for two oral antibiotics. This same hospital record indicated it was highly recommended from both the hospital and wound clinic that the resident be admitted to a skilled nursing facility however the resident refused and returned to the assisted living after a five day hospitalization.

Upon return to the facility, the progress notes indicated the resident had an appointment scheduled a week later back in the clinic. The facility progress notes indicated the resident was determined to preserve his self-sufficiency for walking.

The resident's assessment after hospitalization indicated the resident was alert and oriented to person, place, and time and able to recall and retain information. The resident's vulnerabilities included inability to walk safely due to decreased strength and endurance. Due to pain and edema the resident began using a wheelchair.

Five days later after returning from the hospital, the progress notes indicated the resident was found sitting on the footrests of the wheelchair and he had low oxygen levels. The same documents indicated the skin on his buttocks looked red and irritated. The facility called 911 and transferred the resident back to the hospital.

During an interview, nurse #1 stated the previous hospitalization was related to lymphoedema and infection to the lower extremities. Nurse #1 stated the resident had chronic ulcerations in his gluteal (buttocks) and scrotal area along with significant lower extremity edema. She stated she was unsure whether the resident had allowed incontinence cares during his hospitalization, but the resident had a strong smell of urine when he returned to the hospital.

During an interview, nurse #2 stated resident toileted himself, generally refused showers, and caregivers made attempts to reapproach him for personally hygiene, but the resident frequently refused.

During an interview, a family member stated the resident had been hospitalized multiple times over the past six months for the lower leg and foot edema. The family member stated the resident was signed up for assistance with weekly showers but generally he refused assistance. The family member stated the resident was of sound mind and very capable of making his own decisions. The family member stated that resident's skin was very fragile due to his age and health conditions and was unlikely to report concerns to nursing.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: NA (deceased)
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
Facility sent the vulnerable adult to the hospital immediately when skin condition was detected.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21129	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (MEADOW LAKES) LLC	**22 45TH AVENUE NW ROCHESTER, MN 55901**

(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 5, 2024, through March 6, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL211293520C/HL211297186M. No correction orders are issued.	0 000		