Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21386012M
Compliance #: HL21386013C

Date Concluded: December 3, 2019

Name, Address, and County of Licensee Investigated:
CSL Rose Arbor
16500 92nd Ave No
Maple Grove, MN 55311
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
Amy Hyers, 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.

Allegation(s):
It is alleged: The facility neglected to respond to a change in the client's condition.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client had a known history of chronic wounds and diagnoses that increased the client's risk of acquiring pressure wounds. The facility failed to provide ongoing monitoring and treatment of the client's skin. The client subsequently developed a Stage 2 pressure ulcer on her buttocks.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigation further included a facility tour, observations, record reviews, which included the client's records, hospital records, clinic records, facility incident reports, and facility policies and procedures.

The client received comprehensive home care services for diagnoses that included diabetes Type 2, neuropathy, degenerative joint disease, and a variety of cardiac anomalies. She received

services including shower assistance, donning and doffing support stockings, and medication management. She was essentially independent with the remainder of her personal cares. Her diagnoses created a higher risk for her to develop pressure ulcers. Although she could walk and transfer herself independently, she often required motivation and reminders to do so.

While receiving care at the facility, the client developed Stage 1 and 2 pressure ulcers to her buttocks. A witness and a family member discovered the client's increased skin breakdown and reported it to the facility director of nursing. A progress note dated that day indicated the client had a pressure ulcer on her right buttock that measured 8 centimeters (cm) by 1.5 cm and was beefy red. The left buttock ulcer measured 1 cm by 1 cm, and the tail bone ulcer measured 0.5 cm. A facility nurse further indicated the left buttock and tail bone were Stage 1 ulcers, but the right buttock was a Stage 2 ulcer. The nurse sent the information to the client's primary care physician. The physician ordered skilled nursing wound care in response.

Approximately six months prior to discovery of the Stage 2 ulcer, review of the client's progress notes indicated the client returned to the facility after a post-hospital transitional care stay; she had been away for four weeks. A registered nurse from the facility documented a note the next day which indicated upon assessment that client had a red to purple discoloration to her buttocks that measured "16 by 18 cm." The nurse further referenced that the client had a couple of creams for treatment. The note also indicated the nurse encouraged the client to lay down to off-load pressure to her buttocks. The note entry concluded with "will continue to monitor." The next progress note written was dated approximately five months later (at the time the above pressure ulcers were discovered).

A form titled, "Bath Day Skin Checks to be given to Nurse Immediately after Bath/Shower," completed by the nurse at the same time as the progress note included a body diagram. The area of redness was circled on the diagram and a written note indicated the client had redness on her tail bone/buttocks area. Review of the client's chart yielded no further forms of this nature.

A nursing assessment completed by a nurse approximately three weeks later indicated the client had open skin areas: "Right buttocks 0.5 by 1 by 1 open, 15 by 15 discoloration; Left buttocks 1 by 1 open, 15 by 15 discoloration." The nurse documented that an outside home care agency would provide dressing changes to the wounds three times per week with "in-house monitoring" once per week. The nurse further documented the client had occasional complaints of pain and was at-risk for skin breakdown when sitting in one position for long periods of time.

The next nursing assessment completed approximately three months later indicated the client had open skin areas: "Right buttocks 0.5 by 1 by 1 open, 15 by 15 discoloration; Left buttocks 1 by 1 open, 15 by 15 discoloration." The nurse documented that an outside home care agency would provide dressing changes three times per week to the wounds with "in-house monitoring" once per week. The nurse further documented the client had occasional complaints of pain and was at-risk for skin breakdown when sitting in one position for long periods of time. The

assessment indicated staff should use repositioning and medications to relieve pressure on the client's skin.

During the investigation, the investigator contacted the home care agency to request records. The home care agency staff indicated agency staff had not provided any wound care services to the client for several months prior to the client developing the Stage 2 ulcer.

Review of a physician's progress note written approximately five weeks before the Stage 2 ulcer was discovered indicated the client had a small superficial breakdown area to her left buttock that measured 4 millimeters (mm) by 4 mm. One month before the Stage 2 ulcer was discovered, the client's medication administration record (MAR) indicated Remedy Nutrashield, a barrier cream, should have been applied to the affected skin areas as needed. The MAR indicated there were no doses administered by facility staff during the entire month.

During an interview, a family member stated the client often told her she would ask staff to assist her by applying creams, but "they (staff) wouldn't help." The family member was present when an external nurse discovered and evaluated the client's wound. The family member said it was much bigger than it had been in the past.

During an interview, the external nurse stated she was aware the client had a history of chronic wounds to her buttocks. She stated when she saw the client's wound it appeared worse (than what the physician had seen and documented five weeks earlier). The nurse asked the client if a facility nurse had assessed the wound recently. The client told her that no nurse had looked at it, but occasionally an aide would put cream on the wound for her. The nurse said it was a large Stage 2 ulcer. She stated she reported the ulcer to the facility's director of nursing.

During an interview, a facility nurse said weekly skin monitoring should be done by staff during shower assistance. She said wound care was typically done by the licensed practical nurse on duty during the week, but any nurse could do it. The facility nurse indicated that if there were any changes in condition to the skin that the changes would be charted by the nurse.

During an interview, another facility nurse said when the home care agency was not available, the facility nurses did wound care. The nurse further stated any physician order changes were communicated to the home care agency. He later said he did not recall if the home care agency was actually involved with the client's care at the time in question. The nurse said he could not recall if he actually assessed the client's buttocks directly for the purpose of documentation on the skin assessment. He stated if he did not visualize the client's wound himself, he would have used the home care agency's documentation of the wound description (which, at that time, would have been at least six months old).

In conclusion, neglect was substantiated. The facility did not provide on-going monitoring or interventions as documented in the client's record. As a result, the client acquired a Stage 2 pressure ulcer.

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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. Not available for interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21386	A. BUILDING: _____ B. WING _____	C 10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CSL ROSE ARBOR LLC	9251 BLACK OAKS LANE NORTH MAPLE GROVE, MN 55311

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On October 7, 2019, the Minnesota Department of Health initiated an investigation of complaints #HL21386012M/#HL21386013C and #HL21386014M/#HL21386015C . At the time of the survey, there were 74 clients receiving services under the comprehensive license. The following correction order is issued for #HL21386012M/#HL21386013C, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325 SS=G	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights:	0 325		

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0 325	Continued From page 1 (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee staff neglected to respond to a significant change in condition for 1 of 2 clients (C1) reviewed when staff did not provide ongoing monitoring and treatment of C1's skin. C1 developed a Stage 2 pressure ulcer unbeknownst to the staff. This practice resulted in a level three violation (a violation that harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 was admitted to the facility on March 19, 2011, for diagnoses that included diabetes Type II, neuropathy, degenerative joint disease, and a variety of cardiac anomalies. C1 received comprehensive home care services including shower assistance, donning and doffing support stockings, and medication management according to a service log dated June 2019. Document review of C1's progress notes indicated she returned to the facility after a	0 325		

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0 325	Continued From page 2 post-hospital transitional care stay on January 29, 2019. She had been away for four weeks. A registered nurse (RN)-D documented a note the next day that indicated upon assessment, C1 had a red to purple discoloration to her buttocks that measured "16 by 18 cm." He further wrote, "Resident has a couple of creams for treatment." The note also indicated he encouraged C1 to lay down to off-load pressure to her buttocks. The entry concluded with, "Will continue to monitor." The next progress note written was dated July 8, 2019. A form titled, Bath Day Skin Checks to be given to Nurse Immediately after Bath/Shower, completed by RN-D and dated January 28, 2019, included a body diagram. The area of redness was circled on the diagram and a written note indicated, "Resident has redness on her tail bone/buttocks." Review of C1's chart yielded no further forms of this nature. Document review of a nursing assessment completed by RN-D on February 18, 2019, indicated C1 had open areas: "Right buttocks 0.5 by 1 by 1 open, 15 by 15 discoloration; Left buttocks 1 by 1 open, 15 by 15 discoloration." The assessment contained a category titled, Who Will Treat Wound. RN-D documented (Named) home care will provide dress changes three times per week with "in-house monitoring" once per week. RN-D further documented C1 occasionally had complaints of pain and a risk factor for skin breakdown was C1 "sitting in one position for longer times." A final section of the assessment contained a question as follows: Resident utilizes skilled or Medicare-Certified Care; the answer charted was "Yes." Document review of a nursing assessment	0 325		

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0 325	Continued From page 3 completed by RN-D on May 22, 2019, indicated C1 had open areas: "Right buttocks 0.5 by 1 by 1 open, 15 by 15 discoloration; Left buttocks 1 by 1 open, 15 by 15 discoloration." The assessment contained a category titled, Who Will Treat Wound. RN-D documented (Named) home care will provide dressing changes three times per week with "in-house monitoring" once per week. RN-D further documented C1 occasionally had complaints of pain and a risk factor for the skin breakdown was C1 "sitting in one position for longer times." The assessment included a category titled, Relieving factors: RN-D charted, "Re-positions, medications." Document review of a physician's progress note dated May 30, 2019, indicated C1 had a small superficial breakdown area to her left buttocks that measured 4 millimeters (mm) by 4 mm. Document review of C1's medication administration record (MAR) dated June 2019 depicted an order for Remedy Nutrashield, effective March 6, 2019, a barrier cream to be applied to affected area as needed. According to the MAR, there were no doses administered the entire month of June 2019. A progress note dated July 7, 2019, indicated C1 had a pressure ulcer on her right buttocks that measured 8 centimeters (cm) by 1.5 cm and was beefy red. The left buttocks was 1 cm by 1 cm, and the tail bone was 0.5 cm. RN-D further indicated the left buttocks and tail bone were Stage 1 ulcer, but the right buttocks was a Stage 2. RN-D sent the information to C1's primary care physician. The physician ordered skilled nursing wound care in response. During the investigation, the home care agency	0 325		

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0 325	Continued From page 4 was contacted to request records. The home care agency responded that agency staff last provided care to C1 in November 2018. During an interview on November 1, 2019 at 2:17 p.m., a family member (FM)-B stated C1 often told her she would ask staff to assist her by applying creams, but "they (staff) wouldn't help." FM-B stated she was present when an external nurse (RN)-A evaluated the wound on July 8, 2019. FM-B said it was much bigger than it had been in the past. During an interview on October 25, 2019 at 3:39 p.m., RN-A stated she was aware C1 had a history of chronic wounds to her buttocks. She stated she had the physician's note from May 22, 2019. When she saw the wound, she said it was worse (than what the physician observed and documented five weeks earlier). RN-A asked C1 if a nurse had assessed it recently. C1 told her no nurse had seen her, but occasionally, an aide would put cream on it for her. RN-A said, at that time, C1 had a large Stage 2 ulcer. RN-A reported the ulcer to the facility's director of nursing (DON). During an interview on November 1, 2019 at 9:18 a.m., RN-E said weekly skin monitoring should be done during shower assistance. She said wound care was typically done by the licensed practical nurse (LPN) on duty during the week, but any nurse could do it. RN-E stated that if there were any changes in condition then "there would be charting by the nurse." During an interview on November 4, 2019 at 4:09 p.m., RN-D said when the home care agency was not available, the facility nurses did wound care. RN-D further stated any physician order changes	0 325		

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0 325	Continued From page 5 were communicated to the home care agency. He later said he did not recall if the home care agency was actually involved at the time in question. RN-D said he could not recall if he actually assessed C1's buttocks directly on May 22, 2019. If he did not visualize C1's buttocks directly, he said he would have used the home care agency's documentation of the wound description (which would have been at least six months old). Document review of an undated policy titled, Bathing Assistance, indicated when assisting a client with bathing, staff are to monitor for any change noted in the client's status...be sure to monitor for changes in the condition of the client's skin (e.g. redness, rashes, bruises, skin breakdown). Document review of a policy titled, Assessment -Schedule Policy, last revised on January 31, 2018, indicated an RN should complete a change in condition assessment of a client as indicated. Time period for correction: Seven (7) Days.	0 325		