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 #: HL282616263M
Compliance #: HL282611905C

Date Concluded: October 5, 2023

Name, Address, and County of Licensee Investigated:
The Glenn Minnetonka
5300 Woodhill Road
Minnetonka, MN 55345
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 facility did not provide adequate wound care leading to in the resident's hospitalization due to a wound infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did develop a wound infection and required hospitalization, the facility provided appropriate assessment and wound cares leading up to this hospitalization. The resident received antibiotic treatment and returned to the facility after four days.

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

the resident's external medical record. The investigation included an onsite visit, observations, and interactions between current residents and facility staff.

The resident resided in an assisted living facility. The resident’s diagnoses include quadriplegia and stage 3 pressure ulcer of sacral region. The resident's care plan required the assistance of two persons and the use of a hoyer lift for all transfers, dressing changes, and toileting. The resident’s care plan included tilting the electric chair 30-45 degrees for a minimum of 30 minutes every 2-3 hours to prevent pressure sores, as well as laying the resident down for 1-2 hours after lunch. The resident's assessment also indicated he had wounds on the coccyx and upper posterior thigh, the resident would need to be repositioning every 2 hours by the staff.

The medical provider's orders indicated wound care was required provided three times a week by the outside agency. The home health agency provided wound care twice a week and a wound care specialist one a week. The facility staff would provide wound care as needed.

The wound care specialist's notes from one week before the incident occurred indicated the wound was deteriorating. Five days before the resident was sent to the hospital, the wound underwent debridement, and it was noted that there was "no change in progression" with no signs of infection at that time. The primary goal for the resident's wound care was the removal or debridement of nonviable tissue and the prevention of infection.

The resident's progress notes indicated the dressing for the wound was changed one day before the resident was sent to the hospital, as well as on the day when the resident was transferred to the hospital.

During an interview, nurse #1 stated she had been caring for the resident for over a year and a half. She mentioned that a recurring pattern was observed with his wounds: as one would start to heal, another would develop. Throughout the entire time she worked with him, the resident was unable to reposition himself and required the use of a hoyer lift for transfers. The nurse confirmed she had seen the wound just four days before the resident was sent to the hospital. At that time, the tissue appeared to be in good condition, displaying a healthy pink color, and it was covered with a 3x3 foam dressing. However, she mentioned that she received a call four days later indicating the dressing was running out, which was unexpected because she had provided the staff with a 10-week supply of dressings. Upon visiting the resident, she found the wound had quadrupled in size, with the debrided area turning black due to necrotic tissue. A foam-like substance had developed on top of the wound. Additionally, redness extended 8 cm above and 10 cm below the wound and all the way to the back of the resident's hip. It was reported multiple bandages had been applied over the weekend, ranging from 3 to 4 layers at a times.

During an interview, nurse #2 reported she worked on that weekend but did not personally observe the resident's wound. She stated the direct care staffs followed the protocol of turning

the resident every 2 hours, and it was the responsibility of the direct care staffs to notify the nurse if the dressing appeared to be saturated and needed changing.

During an interview, nurse #3 stated he worked the weekend when the resident's wound changed. Since he had not previously cared for the resident, he was unaware of how the wound was supposed to appear. He explained the facility's nurse was responsible for providing care as needed, especially since the resident received wound care services from an outside agency. Nurse #3 confirmed he had called and discussed the resident's rapidly deteriorating wound with the outside agency staff. Additionally, he acknowledged changing the dressing twice during the night due to excessive drainage. Nurse #3 also made a call to the medical provider to provide updates on the worsening condition of the wound in the morning on the day the resident was sent to the hospital.

During an interview, unlicensed caregiver #1 mentioned she did not recall specific details from that particular weekend, but she was aware the resident had a wound on his buttocks. She explained the nurse would change the wound dressing whenever it became saturated or soiled. Additionally, she mentioned the direct care staff took turns repositioning the resident every 2 hours as part of their routine care duties.

During an interview, unlicensed caregiver #2 stated she did not provide direct care to the resident that weekend. However, she observed other direct care staff members entering the resident's room and repositioning him every 2 hours as per the care plan.

During the investigation, despite making multiple attempts, the investigator was unable to reach the family members.

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: No. The resident was deceased.

Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28261	A. BUILDING: ________ B. WING ________	C **10/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GLENN MINNETONKA	**5300 WOODHILL ROAD** **MINNETONKA, MN 55345**

(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 September 7th 2023, the Minnesota Department of Health initiated an investigation of complaints #HL282611905C/HL282616263M. No correction orders are issued.	0 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE