

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL287909645M
Compliance #: HL287907468C

Date Concluded: June 17, 2024

Name, Address, and County of Licensee

Investigated:

Towerlight on Wooddale Avenue
3601 Wooddale Avenue South
St. Louis Park, MN 55416
Hennepin County

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

Evaluator's Name:

Maerin Renee, 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):

It is alleged: The facility neglected the resident when staff failed to identify a toe infection. The infection progressed and the resident's toe was amputated.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to document, report, and assess necrotic (dead) tissue on the resident's left great toe. An infection in the resident's bone had already developed and the toe required partial amputation to manage the tissue death and bone infection.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, facility incident reports, personnel files, staff schedules, and

related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included peripheral autonomic neuropathy and legal blindness. The resident's service plan included assistance with bathing/showering, toileting, dressing, monitoring skin condition, nail care, transfers, walking, medication management, laundry, housekeeping, and coordination of care.

The resident's assessment indicated the resident was oriented to person/place/time, but vulnerable to falls and required an assist of two for transfers and an assist of one for activities of daily living. The resident experienced numbness and tingling to his left hand and both legs from the knees down due to the neuropathy.

The resident's progress notes indicated the resident was seen by in-house podiatry for foot/nail care approximately two months before hospitalization. Podiatry recommended a follow-up in 9-12 weeks, or sooner if problems arose.

The residents medical record contained no further documentation regarding the condition of the resident's feet until a note nearly two months later, when the resident was hospitalized after a fall. The note indicated hospital staff informed the facility the resident was diagnosed with osteomyelitis, a bone infection, to his left great toe and required a partial amputation.

The resident's service plan indicated unlicensed staff (ULP) were to monitor the resident's skin while doing cares and report concerns to nursing. The resident's service record the month before his hospitalization indicated unlicensed staff signed off on skin condition monitoring three times a day every day that month. The following month the resident's service record indicated staff completed skin condition monitoring one to three times a day until his hospitalization. Staff did not document concerns regarding the resident's feet, nor was there documentation of concerns reported to nursing.

The resident's nursing assessment three months prior to resident's hospitalization indicated the resident had no skin concerns that needed treatment or monitoring. There were no further nursing assessments completed between this time and the resident's hospitalization.

A photograph taken at the hospital of the resident's left foot before the toe amputation showed a circular, black lesion at the tip of the resident's left great toe, which encompassed the entire center section of the toe. The toe was reddened and swollen. The surrounding skin on the foot was flaky and flushed. The skin of the toe was peeling off and the toenail was yellowed and misshapen.

The resident's hospital documentation indicated hospital staff discovered an ulceration on the tip of his left great toe. The resident's x-ray findings were consistent with changes related to osteomyelitis (an infection in the bone), and he was placed on intravenous (IV) antibiotics. Small

areas of necrosis (tissue death) were noted on four of the resident's five right toes. The resident underwent a partial amputation of his left great toe and was discharged to a transitional care unit (TCU) after six days in the hospital. The resident returned to the facility after his discharge from the TCU.

When interviewed, a supervisor said no concerns regarding the resident's toe were reported to her. The supervisor said staff were unaware of problems with the resident's toe until hospital staff told them the resident's great toe needed to be partially amputated. The supervisor said staff were expected to check the resident's skin and feet during showering/bathing. Staff reported to the supervisor that the resident complained of pain, but she did not recall the location of his pain.

When interviewed, a nurse said while she prepared for the resident's return from the TCU, she could find no documentation by the facility regarding the resident's toe prior to his hospitalization.

When interviewed, a family member said the family found out about the resident's infected toe when he was hospitalized after falling at the facility. The family member said the resident was numb from the knees down, so he would not have been able to feel pain in his feet. Family members were surprised when hospital staff removed the resident's stockings, and his toe was black.

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, deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility provided and documented wound care as prescribed after the resident returned from the TCU.

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
St. Louis Park City Attorney
St. Louis Park Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2024
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NAME OF PROVIDER OR SUPPLIER TOWERLIGHT ON WOODDALE AVENUE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL287901751C/#HL287902580M and #HL287907468C/#HL287909645M.</p> <p>On May 14, 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 71 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL287907468C/#HL287909645M, tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p>	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p> <p>Please refer to the public maltreatment report for details.</p>	02360	No plan of correction is required for this tag.	