

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL297195623M
Compliance #: HL297199796C

Date Concluded: September 18, 2023

Name, Address, and County of Licensee

Investigated:

The Legacy of St. Anthony
2540 Kenzie Terrace
St. Anthony, MN 55418
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Maerin Renee, 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 they failed to assess, monitor, and follow the resident's plan of care for wound care. The resident developed a methicillin-resistant staphylococcus aureus (MRSA) infection and the wound worsened.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility had arrangements with a home health agency to provide wound care and monitoring. Facility staff monitored the resident's skin during showers and toileting and provided cares per the resident's service plan. Facility staff documented continuous coordination of care with the home care agency providing the resident's wound care. The resident was eventually discharged to a higher level of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's record,

assessments, service delivery records, incident reports, progress notes, and policies and procedures. The investigator toured the facility and observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia, chronic respiratory failure, cardiomyopathy, and sacral wound. The resident's service plan included assistance with activities of daily living, and foley catheter management. The resident's assessment indicated the resident was cognitively intact, at risk for falls, had compromised skin integrity, and required assistance with activities of daily living.

The resident's progress notes indicated a pressure sore on the resident's coccyx was discovered upon his admission to the facility. Facility staff assessed the wound and contacted a provider for wound care orders and supplies. The facility contracted with an outside agency to provide wound care, supplemented by facility staff when the agency nurse was not scheduled to visit. Facility nurses observed the resident's wound when the agency completed the resident's wound care. The resident's progress notes included several descriptions of the observed wound documented by staff. The resident had a history of MRSA infections, and subsequently developed an MRSA infection in his pressure sore. The resident was admitted to the hospital for an unrelated procedure. While the resident was in the hospital it was determined the resident required a higher level of care and would not return to the facility.

During interviews, multiple staff members stated the facility discovered the resident's sacral pressure sore upon admission to the facility. The facility coordinated care with outside providers to obtain wound orders, supplies, and wound care. Wound care was managed by both external providers and facility staff. The resident had a history of MRSA infections, and a staff member ordered testing when she noticed changes on the skin integrity of the resident's penis. The resident tested positive for MRSA, and the facility continued to provide wound care. The resident entered the hospital for a planned procedure, and hospital providers determined the resident needed a higher level of care with around-the-clock skilled nursing care. The resident was admitted to the hospital and then transferred to a higher level of care.

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, no forwarding information was provided.

Family/Responsible Party interviewed: No, did not respond to request for interview.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility staff provided services according to the resident's service plan, provided treatment for the resident's wound, and coordinated wound care with external providers.

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>

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2023
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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY	STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418
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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>#HL297199796C/#HL297195623M, #HL297194122C and #HL297192904C</p> <p>On August 22, 2023, 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 61 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL297199796C/#HL297195623M, #HL297194122C, and HL297192904C, tag identification 0115.</p>	0 000		
0 115 SS=F	<p>144G.10 Subd. 2 Licensure categories</p> <p>(a) The categories in this subdivision are established for assisted living facility licensure.</p>	0 115		

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

Minnesota Department of Health

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0 115	<p>Continued From page 1</p> <p>(1) The assisted living facility category is for assisted living facilities that only provide assisted living services.</p> <p>(2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit.</p> <p>(b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain an assisted living facility with dementia care license when the licensee's facility had a locked unit and the residents could not exit the locked door without entering a code. This had the potential to affect all nine (9) residents residing in the locked unit.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The facility received an assisted living facility license effective August 1, 2021, with a capacity of 97 beds.</p> <p>On August 22, 2023, at 10:00 a.m., the</p>	0 115		

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0 115	<p>Continued From page 2</p> <p>investigator toured the first floor of the facility. A locked door was observed with a keypad on the wall. Next to the keypad a piece of paper taped to the wall had 4 numbers written on it. Written instructed indicated the numbers should be entered backwards to unlock the door. The investigator entered the 4-digit code backwards as instructed and the door unlocked.</p> <p>During observation on August 22, 2023, at 10:00 a.m., a [unknown] resident walked down the hallway in the locked unit and was attempting to open the locked door. The resident did not attempt to use the keypad and turned around and walked down the hallway.</p> <p>On August 22, 2023, at 12:00 p.m., licensed assisted living director (LALD)-A stated a section of the building was designated as the "care suite." The care suite doors to enter and exit were locked. However, the key code was written on a piece of paper next to the keypads, so the unit wasn't considered a locked unit because residents could enter the code to come and go from the care suite area. LALD-A stated she was told corporate leadership applied for an assisted living with dementia care license and the goal was to open the locked dementia care unit by November 1, 2023, after they were able to hire and train dedicated staff. LALD-A stated not all of the residents in the care suite were able to enter the code to exit the locked door.</p> <p>A review of the facility's application, dated March 16, 2023, indicated the assisted living license category applied for was assisted living, with no request for dementia care, and indicated a total licensed resident capacity of 97.</p> <p>The facility policy titled Assisted Living License</p>	0 115		

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0 115	Continued From page 3 and Posting, dated July 1, 2021, indicated the licensee would maintain a current assisted living license issued by the Minnesota Department of Health. TIME PERIOD FOR CORRECTION: Sixty (60) days.	0 115		