

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL299531380M
Compliance #: HL299538759C

Date Concluded: May 30, 2024

Name, Address, and County of Licensee

Investigated:

Dellwood Gardens
753 East 7th Street
Saint Paul MN, 55106
Ramsey County

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

Evaluator's Name: Kris Detsch, 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 a resident when they failed to provide medical care to the resident. The resident had a wound on her leg which became infected. The resident died from the infection.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident had chronic (long term) wounds to her legs and the facility coordinated care with an agency who entered the facility to provide daily wound care to the resident. The facility increased services for the resident to address her declining health. Although the resident died from sepsis (severe infection), the facility coordinated care with the resident's health care providers and sent her to the hospital when her health condition changed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the wound care agency. The investigation included review of the resident's records, wound care records, and physician

reports. Also, the investigator toured the facility and observed staff administer medications and treatments to residents.

The resident resided in an assisted living facility. The resident's diagnoses included venous stasis ulcers (leg wounds caused by poor circulation), chronic obstruction pulmonary disease (COPD), anemia, lymphedema (leg swelling), and heart failure. The resident's service plan included assistance with safety checks, bathing, escorting to meals, and transfers. The resident's nursing assessment indicated she was alert and orientated. The resident was able to communicate her needs and administered her own medications. The resident required continuous oxygen. She slept in a chair as opposed to a bed because of past trauma. She dressed and groomed herself independently.

The resident's nurse practitioner (NP) notes indicated the resident had wounds to both her legs because of poor circulation. There was drainage from the wounds and the surrounding tissue. Slough (non-viable tissue) was present in the wounds. The resident received an antibiotic medication for infection of her wounds one month prior to her hospitalization. The resident's wounds appeared to have less drainage while she received the antibiotic medication, but her wounds did not heal. The resident required further specialized treatment from a wound care clinic. NP notes indicated the resident did not want to go outside of the facility for medical appointments. Additionally, the resident had poor function of her lungs and heart. The NP requested the resident attend appointments with a pulmonologist (lung specialist), and cardiologist (heart specialist). The resident did not want to attend those appointments regardless of the health risks. The NP continued to monitor the resident's lab work and chronic health diagnoses.

Progress notes indicated the day before the facility sent the resident to the hospital, a wound care nurse and a facility nurse spoke to her regarding her wounds. The wound care nurse told the resident she needed to elevate her legs, or her wounds would not heal. The facility nurse added services for staff to assist her with elevating her legs, and showering. The resident was agreeable, as she refused assistance for these tasks in the past. The following day, the facility nurse went to check on the resident. The resident had low blood pressure and an elevated pulse. The nurse was not able to obtain the resident's oxygen saturation level. The nurse also noticed the resident's wounds had a foul odor. The nurse told the resident she thought she should go to the hospital, however the resident said she was not going to go. The nurse convinced her to go to the hospital and coordinated care to get her there.

Wound care documentation indicated wound care nurses provided wound care to the resident twice during the week, prior to her hospitalization. The documentation indicated the wounds showed no signs or symptoms of infection. The wound care nurses spoke to the resident about allowing staff to assist her with showers and elevating her legs. Wound care documentation indicated the resident received wound care the day before the facility sent her to the hospital. Documentation from the visit indicated the resident did not have a fever. Her skin color, and skin temperature were within normal limits. The resident was alert, orientated, and able to

communicate her needs. The wound care nurse and facility nurse educated the resident on the importance of personal hygiene and allowing staff to assist her with showering. Documentation further indicated the resident had an appointment with a wound care specialty clinic the following month.

During an interview, a wound care nurse said the wound care agency provided wound care daily to the resident. The wound care nurse said they tried to provide care three times weekly, however had to increase their services and treat the resident daily because there was so much drainage from the resident's leg wounds.

During an interview, a facility nurse said the day before the resident went to the hospital, she appeared at her baseline health status. The resident denied feeling sick. The facility nurse said she observed the resident's wounds together with the wound care nurse the day before she went to the hospital. The facility nurse said the wound care nurse told her the resident's wounds were not any better, but not any worse. The facility nurse said the following day, she saw the resident and thought she looked sick. The resident's blood pressure was lower, and she had an elevated pulse. The facility nurse sent the resident to the hospital; however, the resident did not believe she was sick.

Medical records indicated the resident died at the hospital seven days later from sepsis (infection).

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. Deceased.

Family/Responsible Party interviewed: No. Attempted but did not respond.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility coordinated care with the wound care agency, and the resident's medical providers. The facility increased services to assist with the residents changing health status.

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: 29953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2024
NAME OF PROVIDER OR SUPPLIER DELLWOOD GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 753 EAST 7TH STREET SAINT PAUL, MN 55106		
(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</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>#HL299535486C/#HL299538266M, #HL299538759C/#HL299531380M, #HL299539105C/#HL299531521M</p> <p>On April 16, 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 eighty-two residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL299535486C/#HL299538266M, #HL299539105C/#HL299531521M tag identification 1620.</p> <p>No correction orders were issued for #HL299538759C/#HL299531380M.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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01620	Continued From page 1	01620			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conduct timely routine and change of condition assessments days for two of three residents (R1, R3) reviewed. The licensee's assessment process lacked identification of assessment due dates and person(s) responsible for completion of the assessments. As a result, this had the potential to affect all residents.	01620			

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01620	<p>Continued From page 2</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 potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 admitted to licensee on October 11, 2022. R1's diagnoses included stroke, hemiplegia, hypertension, cardiomyopathy, post-traumatic stress disorder (PTSD), and psychoactive substance dependence.</p> <p>R1's nursing assessment dated October 24, 2022, indicated R1 tested positive for cocaine when evaluated for stroke at the hospital. R1 required assistance for transfers, ambulation, dressing, bathing, mobility, and toileting.</p> <p>R1's record lacked any further nursing assessments, including routine assessments due every 90 days.</p> <p>Progress notes dated September 2, 2023, indicated staff members found R1 deceased in his apartment.</p> <p>On April 17, 2024, at 10:12 a.m., surveyor requested licensed assisted living Director (LALD)-A to verify if R1's nursing assessment dated October 24, 2022, was the most recent nursing assessment licensee completed for him. Surveyor also requested LALD-A to provide most recent, full nursing assessment.</p>	01620			

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01620	<p>Continued From page 3</p> <p>On April 17, 2024, at 1:31 p.m., LALD -A confirmed the licensee did not complete further nursing assessments for R1, and the assessment dated October 24, 2022, was his most recent nursing assessment.</p> <p>R3 admitted to licensee on March 16, 2020. R3's diagnoses included Alzheimer disease, chronic kidney disease, hypertension, glaucoma, asthma, irritable bowel syndrome, and arthritis.</p> <p>R3's nursing assessment dated November 21, 2023, indicated she had a change in her health condition due to recent hospitalization for hallucinations and confusion. R1 required antibiotic medications because of a urinary tract infection. The assessment indicated R3 required assistance with transfers, toileting, and bathing, but she was independent with dressing and grooming. R3 had mild cognitive impairment.</p> <p>R3's progress notes dated December 6, 2023, indicated R3 tested positive for Covid 19, and she started Paxlovid (anti-viral) medication. R3's cholesterol medication and inhaler required staff to not administer them while she received Paxlovid. On December 12, 2023, R3 appeared to be "washed out and weak" so nursing staff sent her to the hospital.</p> <p>R3's medical record lacked a nursing assessment to identify her change in condition on December 6, 2023.</p> <p>On April 18, 2024, at 10:08 a.m., RN-C said any nurse can complete resident assessments. RN-C said there was no system to alert the nurse if a resident required a 90-day assessment. RN-C said when a nurse completes an admission assessment, they place the subsequent</p>	01620			

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01620	<p>Continued From page 4</p> <p>assessment due dates on a calendar and they would be responsible for completing further nursing assessments, but any nurse could complete them. When asked how nurses knew what assessments required completion in the absence of a nurse, RN-C said she could not answer. RN-C said she did not complete 90-day assessments because she did not focus on those assessments but would try to complete them. RN-C said she completed assessments when there were changes in the resident's health condition.</p> <p>On April 25, 2024, at 9:02 a.m., director of nursing (DON)-D said the computer system has a reports tab and when nurses click on it, there is a list of assessments required for completion. When asked how nurses know which assessments, they are responsible to complete, DON-D said the nurse on second floor is an LPN, so basically, it's her and RN-C who complete assessments. DON-D said the computer system generates assessment schedule based on when the last assessment was completed. DON- D said she completes assessments for residents who live on third floor and RN-C has been completing assessments for residents who live on fourth floor. DON- D said she has also started doing assessments for the residents who live on second floor. DON-D said prior to her becoming DON, she did assessments for residents who lived on third floor, and RN-C for the residents who lived on fourth floor. The former DON completed assessments for the residents who lived on second floor. DON-D said nurses were to complete nursing assessments for the floor they worked on. DON-D said, the nurses see all the residents on all floors, and manage their care.</p> <p>On April 26, 2024, at 1:22 p.m., former DON-B</p>	01620			

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01620	<p>Continued From page 5</p> <p>said there was a system set up where staff were supposed to look at assessments and add them into the resident's services. DON-B said they had a calendar set up for things nurses needed to be complete. When asked how the nurses know which assessments, they were responsible to complete, DON-B said there is an assessment report you can look it up by assessments due, which is what we have been doing most of the time. DON-B said they tried to have nurses complete the assessments based on the floors at the facility. DON-B said if they had trouble getting to somebody, they would ask each other to help. Regarding R3, DON-B said she should have completed a nursing assessment to address her change in health condition when she tested positive for Covid 19. DON-B said she missed the assessment, but R3 did not require further services because she had services in place to address her health status. DON-B said she placed information for staff to direct care for R3 on the medication administration record (MAR).</p> <p>Licensee policy titled, 6.01 Assessments, Reviews, and Monitoring, dated February 4, 2024, indicated licensee would complete ongoing resident reassessments and monitoring as needed based on the changes in the needs of the residents and would not exceed 90 calendar days from the date of the last assessment.</p> <p>Time period for correction: Seven (7) days</p>	01620			