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 #: HL303323881M
Compliance #: HL303324356C

Date Concluded: August 23, 2024

Name, Address, and County of Licensee Investigated:
Goldpine Home
1700 30th Street NW
Bemidji, MN, 56601
Beltrami County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 the facility staff failed to provide incontinence care and arrange for a provider visit when the resident developed cellulitis (a swollen and inflamed skin infection.)

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided incontinent care services according to the resident's service plan, monitored the resident's skin, and provided skin care as the resident allowed. The facility scheduled an appointment for the resident to be seen for a skin evaluation, however the resident chose not to go. About one week later, when the resident's lower leg cellulitis worsened, facility staff arranged for the resident to be evaluated at an emergency room.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident records and hospital records. Also, the investigator toured the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with toileting three times daily and wound care. The resident was incontinent of bowel and bladder. The resident had areas of weeping skin of the lower legs. The resident was disoriented which varied by time of day, had agitation, and was resistive to care.

The resident's record indicated the resident developed lower leg swelling and weeping areas. The facility set up an appointment for the resident to be seen at a clinic by the resident's provider however, the resident chose not to go to the appointment. Facility staff updated the provider on the resident's condition and received orders to treat the resident's leg swelling with a diuretic (medication to remove extra fluid) for five days. The resident's skin was monitored, and skin care was provided as the resident allowed.

A week and a half later, the resident was confused and "highly agitated." The resident's lower legs were painful, red, warm, and was weeping. The resident did not want staff to touch her leg. Facility staff arranged for the resident to be evaluated at an emergency room.

Hospital records indicated the resident was diagnosed with severe Alzheimer's dementia with agitation, cellulitis of lower extremities and a bladder infection. The resident returned to the facility with prescribed antibiotics and a diuretic.

The resident's scheduled services record indicated the resident received toileting services as indicated on the service plan. The record also indicated the resident received skin care services as the resident allowed.

During an interview, a nurse stated the resident was experiencing an overall health decline. The facility monitored and provided skin care to the resident's swollen legs which was not a new condition for the resident. The resident's legs swelled and started to weep. The facility attempted to have the resident seen at a clinic, however the resident chose not to go to the scheduled appointment. The nurse stated facility staff updated the provider and received orders for a diuretic which was effective. The facility monitored the resident's skin, provided dressing changes, and encouraged lower leg elevation as the resident allowed. When the lower legs became red and warm, facility staff arranged for the resident to be evaluated at an emergency room.

During an interview, another nurse stated the resident was not alert and oriented. The day the resident was sent into the emergency room the resident would not allow staff to assist her, would not get out of bed, and was also combative. The nurse stated the resident's legs had new areas of weeping and staff arranged for the evaluation at an emergency room. The nurse stated

following the resident's evaluation, the resident returned to the facility. Prior to the emergency room visit, the resident's skin was monitored, and the resident had dressings applied to lower extremities. The nurse stated, at times, the resident removed or kicked the leg dressings off and also kicked away the pillow staff used to elevate the resident's legs while lying down. At times, the resident was not accepting of receiving incontinent care services from staff and the resident also had a history of removing her incontinent brief.

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, unable to locate.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided incontinence care and skin care as the resident allowed. The facility sent the resident into the emergency room for evaluation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30332	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDPINE HOME	**1700 30TH STREET NW BEMIDJI, MN 56601**

(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 July 30, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL303324356C/#HL303323881M. No correction orders are issued.	0 000		

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