Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303393364M
Compliance #: HL303393543C

Date Concluded: October 16, 2024

Name, Address, and County of Licensee Investigated:
Long Lake Assisted Living LLC
345 North Brown Road
Long Lake, MN 55356
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, 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 failed to follow the resident's plan of care which resulted in the resident acquiring an infection and cellulitis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility followed the resident's plan of care which included regular showering. When staff observed the infection during a shower, staff reported the infection to the nurse and medical care was provided.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff assisting residents into the shower on their scheduled shower day.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, obesity, and dysthymia. The resident's service plan included assistance with showers. The resident's assessment indicated the resident was forgetful but oriented to person, place, and time.

The resident's progress note indicated the nurse was called to the shower room to assess the resident. The nurse documented the resident had red, warm, excoriated areas under the resident's left breast that appeared to be cellulitis (bacterial skin infection). The nurse observed redness under the resident's abdomen as well. The resident reported it had been like this for a day or two but did not report it. The nurse called 911 and sent the resident to the hospital.

The hospital record indicated facility staff sent the resident to the hospital after the facility staff found redness and swelling under the resident's breast. The resident admitted to the hospital and diagnosed with a yeast infection and cellulitis. After intravenous (IV) antibiotics and anti-fungal medications, the resident was sent back to the facility with orders for a probiotic, oral antibiotic, and anti-fungal medications.

Upon hospital return, the resident's medication administration records indicated the resident received the medications ordered while at the hospital.

The resident's service delivery records failed to include bathing as a scheduled service unlike the resident's other scheduled services. However, staff handwrote "bathing" into the record as an unscheduled service. Some months demonstrated consistency with documenting the completion of baths, including the month of the infection, whereas other months demonstrated inconsistencies with documentation.

During an interview, unlicensed personnel (ULP) #2 said she assisted the resident a couple days before the resident was sent to the hospital and noted redness under her breast. She reported the redness, and the nurse assessed the area.

During an interview, ULP #1 said she observed redness and drainage under the resident's breast while showering the resident. She reported it to the nurse who assessed the area and sent her to the hospital. She stated she was trained to report any change in condition to the nurse.

During an interview, the nurse said ULP #1 observed the skin issue while showering the resident and reported it to her. The nurse assessed the resident and found the skin was red and warm. She sent the resident to the hospital. She said two days before she sent the resident to the hospital, ULP #2 gave the resident a shower and observed redness under her breast. ULP #2 reported it to the nurse who assessed the redness and applied Nystatin (medication for yeast) powder and they planned to monitor the area. The nurse said at that time the redness was minor, without drainage, or swelling. She said the resident had a standing order for Nystatin powder because she frequently had issues with yeast under her breasts. She said it was difficult

to keep the area dry and free from infection as the resident often declined interventions. The nurse said this incident was not documented in the resident's record.

During an interview, a member of management said a nurse reported to her the resident was sent to the hospital for swelling and redness under her breast. The resident was diagnosed at the hospital with a yeast infection and cellulitis. She said a staff member observed the issue while assisting the resident with a shower. Staff reported their observation to the nurse and the nurse assessed the resident and sent her to the hospital. The resident returned to the facility where she continued treatment. The infection and yeast resolved, and the resident's health returned to normal.

During an interview, the resident said staff assisted her with showers regularly. She said she had symptoms a few days before they sent her to the hospital but never reported her symptoms. She liked living at the facility and received good care. The area healed and she was complaint with treatment to prevent future occurrences.

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: Yes.
Family/Responsible Party interviewed: Not applicable. The resident was her own person.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital and completed all follow up treatments. The facility staff provided bathing services as required.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30339	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE ASSISTED LIVING LLC	345 NORTH BROWN ROAD LONG LAKE, MN 55356

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL303393543C/HL303393364M On September 23, 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 38 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL303393543C/HL303393364M, tag identification 0730.	0 000	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of completed bathing services in the resident's record as required for one of one resident (R1). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type 2 diabetes, obesity, and dysthymia. R1's service plan dated May 1, 2023, indicated she received assistance with bathing four times a week on Sunday, Monday, Thursday and Saturday. R1's "Staff Charting Form" (a service delivery record) dated March 2024, indicated bathing was not included as a scheduled service for staff to complete. Unlicensed personnel (ULP) handwrote in "bathing" "Sun, Wed, Fri" under "additional service" and documented R1 received baths on March 1, 2024, March 27, 2024 and March 29, 2024	0 730		

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0 730	Continued From page 3 R1's service delivery record dated April 2024, indicated bathing was not included as a scheduled service for staff to complete. ULP handwrote in "bathing" under "additional service" and documented R1 received one bath for the month on April 5, 2024. R1's hospital record indicated R1 was admitted on April 26, 2024, for a fungal infection and cellulitis. R1's service delivery record) dated May 2024, indicated bathing was not included as a scheduled service for staff to complete. ULP handwrote in "bathing" "Sun, Wed, Fri" under "added service" and documented R1 received baths on May 3, 5, 8, 10, 11, 12, 15, 17, 19, 24, 26, 29, 31 of 2024. R1's record failed to identify the fourth bath R1 required. R1's service plan updated June 13, 2024, indicated there was no change with R1's bathing service. The service indicated R1 continued to require bathing assistance four times a week on Sunday, Monday, Thursday and Saturday. R1's service delivery record dated June 2024, indicated bathing was not included as a scheduled service for staff to complete. ULP handwrote in "bathing" "Sun, Wed, Friday" under "additional service" and documented R1 received baths consistently on the three baths day indicated. R1's service delivery record dated July 2024, indicated bathing was not included as a scheduled service for staff to complete. ULP handwrote in "bathing" under "additional service" and documented R1 received one bath for the	0 730		

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0 730	Continued From page 4 month July 21, 2024. R1's service delivery record dated August 2024, indicated bathing was not included as a scheduled service for staff to complete. ULP handwrote in "bathing" under "additional service" and documented R1 had not received a bath until August 14, 2024 and received 10 baths the remainer of the month. R1's service delivery record dated September 2024, failed to include bathing as a scheduled service for staff to complete. R1's record lacked documentation R1 received baths in during the month. During and interview on September 23, 2024, at 10:50 a.m., ULP-C said R1 took showers on Sunday, Wednesday and Friday. ULP-C said for the most part R1 took showers every time it was her shower day. On September 23, 2024, at 11:40 a.m., licensed assisted living director (LALD)-A stated resident baths were documented on the Staff Charting Form. MDH surveyor reviewed the Staff Charting Form with LALD-A. LALD-A acknowledged R1's Staff Charting Form lacked documentation of bathing. During an interview on September 23, 2024, at 12:15 p.m., R1 said she took showers on her scheduled shower day. The licensee's Bathing Assistance policy dated June 2021, indicated staff must notify the registered nurse of new skin conditions and document bathing assistance provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 730		

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0 730	Continued From page 5 (21) days	0 730		