*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL303611741M
**Compliance #:** HL303613259C

**Date Concluded:** September 5, 2022

**Name, Address, and County of Licensee Investigated:**
Arbor Park Living Center LLC
2941 6th Avenue North
Moorhead, MN 56560
Clay County

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

**Evaluator's Name:** Jill Hagen, RN,
Special Investigator

**Finding: Not Substantiated**

**Nature of Visit:**
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 were unable to provide care to a pressure ulcer according to the provider's orders. The resident required a higher level of care than could be provided at the facility.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The resident admitted to the facility with a Stage 3 (loss of full thickness of the skin extending to the subcutaneous skin layer) pressure ulcer on the right hip. Facility staff made referrals for outside agencies to assist them with the pressure ulcer management. Despite the interventions, the pressure ulcer worsened, and the resident required hospitalization for surgical interventions and antibiotics to promote wound healing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical, hospital, and home care records, staff schedules, and policies and procedures. The investigator made on-site observations of the facility.

The resident resided in an assisted living memory care unit with diagnoses that included quadriplegia (paralysis of the legs and arms) and a Stage 3 right hip pressure ulcer. The resident's service plan included staff assistance to complete all activities of daily living including transfer assistance with a mechanical sling lift. The resident was dependent on an electric wheelchair for mobility. The resident was able to make his needs known to others.

The resident's medical record indicated the resident admitted to the facility with a Stage 3 pressure ulcer to the right hip. Facility staff began daily dressing changes to the ulcer according to the provider orders. In addition, the resident was assessed at a wound care clinic on a regular basis. Approximately three weeks after admission, staff arranged for the resident to have the wound evaluated at a hospital due to the resident experiencing fever with chills. The resident's wound was debrided (damaged tissue removed) and the resident was started on oral antibiotics. The wound showed no signs of infection. The resident discharged from the hospital two days later with orders for dressing changes to the right hip pressure ulcer two times a day. Facility staff completed the dressing change one time per day and referred the wound care to an outside home care agency one time per day.

One week later, the resident's provider debrided the right hip pressure ulcer and continued with two time a day dressing changes. Over the next month, facility staff, licensed home care nurses, a wound clinic and the resident's provider assessed the resident's pressure ulcer. At the end of the month, the wound clinic debrided the resident's pressure ulcer and a wound vac (dressing to the wound attached to a suction) was applied with dressing changes two time a week. Over the next week, staff noticed tunnelling of the wound with odor. Facility staff arranged for the resident to be evaluated at a hospital.

The hospital record indicated the resident required wound and right femur (upper leg bone) debridement, intravenous (IV) and oral antibiotics for osteomyelitis (bone infection) and plastic surgery for a skin graft to cover the open wound. The resident required long term IV antibiotics to promote continued healing and was transferred to a facility that provided a higher level of care.

The home care record indicated despite on-going education to remain off the right hip from their staff and facility staff, the resident chose to frequently be positioned on his right side.

During an interview, the nurse stated the resident was admitted to the facility from a private home with a current Stage 3 pressure ulcer on the right hip. Despite staff education and

encouragement, the resident frequently preferred to be positioned on his right side. The nurse stated when changes occurred with the pressure ulcer, staff arranged for the resident to be evaluated at a hospital. In addition, referrals were made to an outside agency and the wound clinic to promote healing of the pressure ulcer. The nurse stated following the hospitalization, the resident would be admitted to a facility that provided 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, attempted without response.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not applicable.

**Action taken by facility:**
No action taken.

**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 |
|---|---|---|---|
| | 30361 | A. BUILDING: _____ B. WING _____ | C 08/03/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBOR PARK LIVING CENTER LLC | 2921 6TH AVENUE NORTH MOORHEAD, MN 56560 |

| (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<br><br>Initial comments<br>******ATTENTION****** ******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction order is issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL303612408C/#HL303611321M<br>#HL303613259C/#HL303611741M<br>#HL303613930C/#HL303612262M<br><br>On August 3, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 40 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for #HL303613930C/#HL303612262M, tag identification 2360. | 0 000 | The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction.<br><br>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction."<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3. | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, | 02360 | | |

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| ARBOR PARK LIVING CENTER LLC | 2921 6TH AVENUE NORTH MOORHEAD, MN 56560 |

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| 02360 | Continued From page 1<br><br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected.<br><br>Findings include:<br><br>On August 3, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.<br><br>No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details. | 02360 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |