Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304085401M
Compliance #: HL304087520C

Date Concluded: September 30, 2024

Name, Address, and County of Licensee Investigated:
Vitality Living of Park Rapids
18846 Eagle Bend Road
Park Rapid MN 56470
Hubbard County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 resident presented with multiple wounds and pressure ulcers. The facility failed to properly care for the resident's toe wound, resulting in the presence of maggots in the wound. The resident sustained a toe amputation and severe pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility completed wound care as ordered by the provider and communicated to the providers timely. The resident had a history of non-compliance with his wound care and would remove bandages.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident. The investigation included review of the resident records, hospital records, staff schedules, and related facility policy and procedures. The law enforcement report was not available for review. Also, the investigator observed staff providing resident care while on site.

The resident resided in an assisted living facility. The resident's diagnoses included atrial fibrillation and stasis dermatitis (skin changes resulting from poor circulation) of both legs. The resident's service plan included assistance with skin care, bathing, toileting, and wound care. The resident's assessment indicated the resident walked independently with the use of a walker and exhibited memory problems.

Medical records indicated the resident admitted to the facility over two years ago with history of chronic wounds to both legs related to poor circulation in the legs. The resident received wound care services from an external home health care provider as ordered, in addition to the wound care performed at the facility.

The resident's nurse's notes indicated one month prior to the discovery of maggots, the resident had accidently snagged the toenail of his right great toe on his sock during removal, causing the toenail to dislodge and become loose. The resident's primary care provider met with the resident that same day and gave orders for wound care. The following day, staff sent the resident to the emergency room for evaluation of severe pain in the right great toe. While in the emergency room, the resident received intravenous (IV) antibiotics and returned to the facility with oral antibiotic, wound care and follow up podiatry orders for the toe.

The resident's medical notes indicated the resident attended podiatry and interventional radiology appointments as ordered for the evaluation and planning of the potential need for toe amputation. The notes indicated the resident had severe peripheral vascular disease (a condition when arteries narrow or become blocked, reducing blood flow to the legs) resulting in a poor prognosis for wound healing. Due to wound worsening and poor prognosis, medical providers advised toe amputation and scheduled it approximately one month after the initial toe injury.

While awaiting surgery, the resident's wound care notes indicated the resident received daily wound care to the great toe on the right foot. Facility staff performed the wound care as ordered every morning.

The resident service delivery record indicated staff completed wound care to the toe as ordered, and staff noted maggots to the wound less than 24 hours later. Staff sent the resident to the emergency department.

Hospital records indicated the resident had multiple maggots in the toe wound and had no signs or symptoms of distress. The records indicated the facility staff reported to hospital staff there were no maggots in the wound at 6:00 a.m. the day before when they changed the dressing. Facility staff noted the maggots at 4:00 a.m., the next morning, just prior to initiating the next dressing change. The resident admitted to the hospital as the previously scheduled surgery was the next day.

A publication from the National Library of Medicine indicated emerging larvae are 1.7 millimeters (mm) and difficult to detect. Once emerged, the larvae grow rapidly, within 24 hours at human skin temperature, to 7-8.5 mm long. The larvae attain full growth in 50-60 hours.

During investigative interviews, multiple staff members stated the resident was frequently not compliant with completion of wound care and that he would also remove dressings after staff completed dressing changes.

During an interview, a contracted home care nurse stated she felt the facility staff were properly caring for the resident's wounds. The home care nurse stated the facility had interventions in place for wound prevention. The home care nurse stated she cared for the residents wound two days prior to the discovery of the maggots, and there were no concerns of the wound at that time.

During an interview, an unlicensed personnel (ULP) stated she complete the wound care to the resident's toe the morning before she and another staff member discovered the maggots. The ULP stated there were no concerns or signs of maggots at that time.

During an interview, the resident stated the staff treated him well and took care of his wounds. The resident stated he liked living at the facility and denied any concerns about his care. The resident stated there was no pain to his toe prior to amputation and did not know why there would have been maggots in his wound.

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: No, did not respond to request for interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed wound care as ordered by the provider.

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
	30408	A. BUILDING: _____ B. WING _____	C 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING OF PARK RAPIDS LLC	18846 EAGLE BEND ROAD PARK RAPIDS, MN 56470

(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 September 5, 2024, the Minnesota Department of Health initiated an investigation of complaint HL304087520C/HL304085401M. No correction orders are issued.	0 000		