Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306661460M
Compliance #: HL306668896C

Date Concluded: May 23, 2024

Name, Address, and County of Licensee Investigated:
Maplewoods Assisted Living
40170 County Road 257
Cohasset, MN 55721
Itasca County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 staff failed to perform wound care and dressing changes as ordered to a pressure ulcer on the resident's left ankle. The resident's wound worsened, and it was recommended the resident have a below the knee amputation. The resident experienced ten out of ten pain due to the wound; however, staff failed to administer as-needed pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although wound care was not consistently provided in accordance with physician's orders, there was not a preponderance of evidence the actions, or inactions of facility staff, led to the resident requiring to have a below-the-knee amputation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case managers,

home care agency staff, and the resident's primary care provider. The investigation included review of the resident's records, hospital records, facility incident reports, and related facility policies and procedures. At the time of the onsite visit, the investigator observed care and services at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cellulitis (skin infection) of the left lower limb and type two diabetes with diabetic neuropathy (nerve damage). The resident's service plan included assistance with twice daily wound care and weekly wound care supervision. The resident's assessment indicated the resident admitted to the facility with an open area to her left foot and later developed a mid-foot ulcer.

The resident's record indicated three months prior to the left leg below-the-knee amputation (BKA), a physician's order was written to have compression wraps applied to the resident's left lower extremities during the day and removed at night. Documentation over that three-month period indicated the resident refused application of the compression wraps on an almost daily basis. The resident also had an order for a pressure-relieving boot to be worn on her left foot at all times. Documentation indicated over that same three-month period, the resident also refused to wear the boot on an almost daily basis.

Two months before the BKA, the resident developed a new pressure ulcer on her left ankle. Following the development of the new pressure ulcer, the resident's physician wrote orders for a pressure relieving mattress and application of a Rooke boot (a specialized vascular boot that helps prevent skin breakdown) to the resident's left foot. However, the Rooke boot and mattress could not be supplied immediately and due to the delay in delivery, the boot was never applied to the resident's foot and the pressure relieving mattress was not delivered until four days prior to the resident's amputation.

Clinic records indicated the resident met with her primary care provider (PCP) approximately three weeks after orders for the Rooke boot and air mattress were prescribed. The resident decided at this visit that she wanted to proceed with a BKA due to ongoing pain, chronic osteomyelitis (bone infection), and difficulties with wound healing over time.

During an interview, nursing staff acknowledged there were delays in communication with the resident's provider, and wound care was not consistently completed as ordered; however, nursing staff stated they re-educated staff on how to perform wound care and the amputation was completed per the resident's choosing.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Attempts to contact were unsuccessful.
Family/Responsible Party interviewed: Attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reeducated staff on proper wound care and dressing change orders.

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
	30666	A. BUILDING: _____ B. WING _____	R-C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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 June 4, 2024, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint HL306661800M/HL306669602C and HL306661460M/ HL306668896C. Maple Woods Assisted Living has corrected the licensing orders related to the complaint investigations HL306661800M/HL306669602C and HL306661460M/ HL306668896C.	{0 000}		