Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306893344M
Compliance #: HL306895395C

Date Concluded: August 29, 2023

Name, Address, and County of Licensee Investigated:
The Homestead at Coon Rapids
11372 Robbinson Dr NW
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 developed open wounds on both knees, which the facility did not treat.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While the facility observed the resident had band-aids on his knees, the facility did not assess, monitor, or provide wound care to his wounds. Upon admission to the hospital, the resident required treatment for cellulitis of the wound(s) and wound care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and requested hospital documentation. The investigation included review of the resident's

facility record and medical provider notes. Also, the investigator toured the facility and observed staff to resident interactions.

The resident lived in an assisted living memory care unit. The resident's diagnoses included dementia and anxiety. The resident's service plan indicated the resident required assistance of one staff for showering three times a week, and verbal cues to hands-on assistance for dressing. The medical record indicated the resident paced and walked frequently outside his room and did not require assistance to ambulate upon admission. The same documents indicated licensed nurses are to provide monitoring or treatments for wounds and changes in condition.

The resident's hospital records indicated the resident developed weakness and required increased help with transfers and walking so he was transferred to the emergency department for evaluation. Upon arrival in the emergency department, the resident had wounds identified on both knees along with cellulitis and required a wound nurse consult.

The day after admission to the hospital the wound nurse consult indicated the resident had cellulitis surround his knee wound(s) and required oral antibiotics. The same document described the wound(s) as covered with a thick crusty scab brown/black covering the wound bed. The wound was covered with necrotic tissue, wound healing was likely stalled, and the wound could be two weeks or older. The notes indicated both knees were cleansed, and dressing applied. Additionally, the notes indicated there were wounds on both elbows that were cleaned and covered with foam dressings.

In the three weeks prior to the resident's hospitalization, the facility documented providing seven showers. A review of the resident's medical record did not identify communication of concerns regarding the resident's skin.

Six days prior to hospitalization the progress notes indicated the resident was "wearing" band aids on bilateral knees. The progress note indicated the facility nurse asked resident if he recalled what happened and the resident responded he fell and got himself up. The progress note indicated the writer stated to the resident the next time this happens you need to report to staff, and the resident was alert only to himself. A review of the resident's treatment administration record (TAR) indicated licensed staff failed to initiate treatment or monitoring of the resident's knees.

Two days prior to hospitalization, a nursing assessment admission lacked documentation of skin issues.

One day prior to hospitalization, the medical provider visited the resident. However, a review of the resident's medical record did not identify documentation of informing the medical provider of the wounds on the resident's knees.

During an interview, the family member stated upon admission the resident paced in the hallways requiring staff redirection at times. The family member stated while at the facility to visit the resident the facility nurse asked her if she was aware of the scabs on the resident's knees and elbows. The family member stated they were not aware and offered to take resident to the doctor but was told the medical provider was making rounds the next day and the facility nurse would continue to monitor.

During an interview, multiple unlicensed personnel (ULP) stated skin concerns were to be reported to the nurse. ULPs stated on occasion the resident could be combative with cares and at times family would need to come to the facility to calm the resident.

During interviews, the facility nurse stated when staff report concerns the facility tries to determine what happened. The facility nurse stated the facility does simple wound care such as wound cleanse and a band aid if small enough. Unlicensed personnel document when showers are completed or if a resident would refuse. The facility nurse stated she did not remove bandages to assess the wounds and it was her understanding the areas were more like abrasions. The facility nurse stated the facility policy would have been to complete an incident report, but no report was completed. The facility nurse stated she did not know who applied the band-aids.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

No action taken by the facility.

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 651-201-4890 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	C 06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(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 LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an 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: HL306896183M/HL306891660C HL306893344M/HL306895395C On June 13, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL306896183M/HL306891660C and #HL306893344M/HL306895395C. At the time of the investigation, there were 41 residents receiving services under the Assisted Living license. The following correction order is issued for HL306893344M/HL306895395C tag identification at 2310.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 1 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure an individual treatment and a treatment plan was completed, for one of two residents (R2) with records reviewed. Additionally, the facility failed to document to include the signature and title of the person who administered the treatment along with the date and time of administration and if any follow-up procedures were required to meet the resident's needs. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R2 admitted on July 7, 2022, R2's diagnosis included dementia and anxiety. R2's care plan dated July 7, 2022, indicated R2 required hands on assistance for showering, wanders independently into areas and requires redirection. R2's completed services report September 10, 2022, through September 29, 2022, indicated showers were documented by staff on September 11, 2022, September 14, 2022, September 18,	02310		

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02310	Continued From page 2 2022, September 21, 2022, September 23, 2022, September 25, 2022, and September 28, 2022. A review of R2's medical record for this time period did not identify communication regarding any skin concerns. R2's progress note dated September 23, 2022, at 1:35 p.m., indicated the resident had a band aid on each knee. The note did not indicate appearance of the knees, assessment, or an incident report completed. The note did not indicate who reported the concern or who applied the band aids. R2's 90-day Uniform Nursing Assessment dated September 27, 2022, indicated no documented skin conditions. The same document indicted unlicensed staff are to report any concerns to the RN or licensed health professional and they will ensure treatment is current and updated if any changes. The assessment indicated the resident has not had any previous falls and walks independently with no use of assistive devices. R2's progress note dated September 28, 2022, indicated the resident was seen by the nurse practitioner. A review of R2's medical record did not identify an indication the facility informed the nurse practitioner of any concern regarding the resident's knees. R2's progress note, dated September 29, 2022, at 3:04 p.m. indicated the resident required assistance of 3 to 4 staff for transfers and toileting, lethargic and weak. The medical provider was contacted, and resident taken by ambulance to hospital. R2's emergency room dated September 29, 2022, 9:08 p.m., indicated the resident arrived	02310		

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02310	Continued From page 3 with wounds on both knees and erythema. The same document indicated a wound nurse consult was ordered upon admission to the hospital. R2's hospital progress noted dated September 30, 2022, 12:55 p.m., indicated a wound nurse consultation was completed. The same document indicated the resident required oral antibiotics for a cellulitis surrounding the left knee wound and described the wound with a thick crusty scab brown/black covering the wound bed. The wound was covered with necrotic tissue, wound healing was likely stalled, and the wound could be two weeks or older. The notes indicated both knees were cleansed and dressing applied. Additionally, the notes indicated there were wounds on both elbows that were cleaned and covered with foam dressings. A review of R2's medical record did not identify documentation of wound checks, wound care, or a treatment while at the facility prior to hospitalization. During interview on June 13, 2023, at 3:04 p.m., registered nurse (RN)-A stated R2 ambulated independently and with no recorded falls. During an interview on July 20, 2023, RN-A stated she was unsure who applied the band aids on his knees and trusted the license practical nurse would continue to monitor. RN-A stated when she was made aware of the band aids, she did not remove the band aids to assess the areas. RN-A stated an incident report should have been completed but had not been completed. The licensee's Prevention and Treatment of Pressure Ulcers/Pressure Injury policy, revised November 11, 2022, indicated skin will be	02310		

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02310	Continued From page 4 observed daily with cares by the nursing assistance and reported immediately to the designated nurse. The same document indicated weekly skins audits will be performed by the licensed nurse, the residents individualized Care Plan for Skin Integrity needs to be updated with skin concerns and interventions. The same document indicated when a wound is present, daily wound monitoring should included and evaluation of the wound, if no dressing is present or an evaluation of the status of the dressing, if present. The status of the area surrounding the wound (that can be observed without removing the dressing), and the presence of possible signs of infection. TIME PERIOD FOR CORRECTION: 7-days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of two residents reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report for details.	