Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306896183M
Compliance #: HL306891660C

Date Concluded: August 17, 2023

Name, Address, and County of Licensee Investigated:
The Homestead at Coon Rapids
11372 Robinson 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: 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 a staff member failed to follow the medical provider's order for a portable chest x-ray to be done STAT (immediately) and then update the medical provider of the results.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The licensed nursing staff communicated the portable chest x-ray orders as STAT; however, the x-ray company changed the order to ASAP (as soon as possible). Due to a misunderstanding, there was a delay in reporting the x-ray results, however when the results were reported to the medical provider, she gave new medication orders and the resident remained at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included a review of the resident's records, the AP's personnel record, the

facility's policies, incident reports, and records obtained from the portable x-ray company. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident lived in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, and heart failure. The resident's nursing assessment indicated the resident required assistance from staff for toileting, transfers, and ambulation, and medication administration. The same document indicated the resident could communicate her needs.

The resident's progress notes indicated the resident had previously experienced a decline in health. Text message communication between the provider and the licensed nursing staff occurred during this time related to a large hematoma (break in the wall of a blood vessel.) The progress notes indicated the medical provider ordered the resident to be seen at the emergency department (ED). A family member took the resident for evaluation to the ED and returned to the facility the same day with no new orders or changes in care.

The following day resident developed wheezing, cough, and shortness of breath. The medical provider was again updated and ordered lab work for the following day which included nebulizer treatment and a STAT chest x-ray. The same licensed nurse continued to monitor the resident along with update the medical provider and family.

Documents from the portable x-ray company indicated the facility's licensed nursing staff called in the order as a STAT chest x-ray. However, the x-ray company changed the STAT order to an as soon as possible order.

The medical record indicated the portable x-ray was taken the next day and the results indicated mild heart failure.

Four days later, which included a weekend, when the x-ray results were reported to then medical provider, the medical provider ordered furosemide (a medication to remove fluid from the body) once a day but she remained at the facility. Two days later the resident developed chest pain and transferred to the emergency department.

During an interview, the licensed nursing staff stated the STAT chest x-ray order was sent to the portable x-ray company as ordered. The licensed nursing staff stated she thought the chest x-ray was communicated directly to the medical provider as that is what occurred with laboratory results. The licensed nursing staff stated she had been updating the medical provider during the week through text messages and receiving responses.

A review of text messages on provided by the licensed nursing staff indicated text messages were used to update the provider and the provider responded back by text message. The messages included remarks back from the medical provider. The text messages indicated the

medical provider clarified text messages could and could not be used when but not until after the next week had started.

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 Statues, section 626.5572, subdivision 17.
Neglect means neglect by a caregiver or self-neglect.
“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:
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 which is not the result of an accident or therapeutic conduct
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation and provided education to the nurse regarding how x-ray results are reported to the medical 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
	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		

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
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		

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
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		

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
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		

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
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.	