Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307454543M
Compliance #: HL307457744C

Date Concluded: March 29, 2023

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name:
Katie Germann, 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 a resident when they failed to monitor and assess the resident's wounds. The resident developed sepsis and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had multiple wounds and the facility failed to assess, monitor, and provide necessary care to promote healing and/or prevent worsening of the residents' wounds. The residents' wounds worsened resulting in exposed bone and tendon between third and fourth toes.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of medical records, hospital records, home care notes, staff training, and facility policy and procedures.

The resident resided in an assisted living facility with diagnoses including Type 2 Diabetes, peripheral vascular disease, a left great toe amputation, and wounds on both feet. The resident had no active service plan, but facility staff indicated they provided medication management for the resident. The residents most recent facility assessment completed 6 months prior to the incident, indicated the resident had decreased circulation in his feet and legs due to diabetes.

The resident's physician orders indicated the resident was to have skilled nursing home care service come to facility three times per week to change the dressings for the residents' chronic venous wounds on his left ankle and right toes.

The residents home care skilled nursing notes indicated the home care nurse was reviewing the resident's facility medical record and discovered 7 days prior, the physician ordered Keflex (antibiotic) and an X-ray to be completed of the resident's right foot to rule out osteomyelitis (bone infection). The medication had not yet been entered into the medication administration record. The Keflex was delivered by the pharmacy to the facility; however, the antibiotic could not be administered until the facility nurse entered the medication onto the resident's medication administration record.

The resident's provider notes indicated the resident was prescribed Keflex and Bactrim (both antibiotics). The residents home care nurse contacted the provider because the resident was not receiving the antibiotic that had been prescribed a week prior. The note indicated the wounds on the resident's foot were progressively worsening and had foul drainage. The notes also indicated the X-ray ordered 7 days prior had still not been completed.

The resident's medication administration record indicated the resident did not receive Keflex until 7 days after the antibiotic was ordered by the provider.

The resident's facility medical record contained no information regarding the X-ray order or of X-ray results obtained by the facility according to the physician orders.

Documentation from the home care nurse indicated the residents right lateral foot/toes were not improving. "Wounds devitalized tissue. Vital signs within normal limits, MRI tonight, surgeon Wednesday."

The resident's provider notes just prior to the resident being sent to the hospital, indicated the residents venous wound on his right foot, "progressed to the point where he has evidence of exposed bone and tendon between toes three and four." The provider notes also indicated the resident showered daily and the resident's wound dressing was saturated. The notes indicated there was a plan to admit the resident directly to a skilled nursing facility for a higher level of care, however, the resident had increased lethargy, and his lower legs appeared to be infected. The provider sent him to the emergency room instead of the direct admit to the skilled nursing facility due to concerns of sepsis (a blood infection).

The residents medical record indicated the resident was sent to the emergency room, received antibiotics, and was discharged to a skilled nursing facility for a higher level of care.

The resident's facility medical record contained no nursing assessment, interventions, or monitoring of the residents wound.

During interview a facility nurse stated the resident had previous orders for an antibiotic and an X-ray of his foot that were not implemented timely. The nurse stated the orders were faxed to the pharmacy and the X-ray company, but nursing staff did not follow up to ensure the orders were received and/ or implemented. The nurse indicated the orders were not entered into the resident's medical record. The nurse stated she does not have time to complete wound rounds or assessments due to a nursing staff shortage at the facility.

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, unable.
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 651-201-4200 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
Anoka County Attorney
Lino Lakes Attorney
Lino Lakes police department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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.08 to 144G.95, these correction orders are issued pursuant to a complaint 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: #HL307457744C/#HL307454543M #HL307458179C/#HL307454784M On February 16, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 100 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL307457744C/#HL307454543M, tag identification 2310 and 2360.	0 000	Minnesota Department of Health is documenting 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 which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' 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 SUBDIVISION 1-3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310		

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02310	Continued From page 1 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of one resident (R1) reviewed with pressure ulcers and/or wounds. Facility nursing staff failed to ensure the wounds were monitored, and failed to ensure physician orders were implemented to prevent the wounds from worsening. R1's wounds continued to worsen resulting in exposed bone and tendons between the third and fourth toes. 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). Findings include: R1's diagnoses included type 2 diabetes, peripheral vascular disease, a left great toe amputation, and venous wounds on both feet. The licensee was unable to provide a service plan for R1. R1's most recent assessment dated July 14, 2022, indicated R1 had decreased circulation to his feet and legs due to diabetes. There was no	02310		

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02310	Continued From page 2 documentation regarding any wounds. R1's provider note dated January 13, 2023, indicated R1 diagnoses included peripheral vascular disease with lower extremity ulcerations with osteomyelitis (swelling of bone), and multiple ulcerations of right foot and toes. The ulcerations progressed to the point where R1 had exposed bone and tendons between the third and fourth toes with eschar (dead tissue) on the side of the right fifth toe. R1's provider note dated January 13, 2023, indicated R1 wound care order included instructions to keep the wound dry and avoid moisture. The provider note indicated R1 showered daily and occasionally R1's wound was wet. The provider note also indicated R1 had a regular skilled nursing wound care by home health (outside provider) three times per week. In addition, R1 had a new prescription for Bactrim (an antibiotic) and an order for a right foot X-ray on December 27, 2022. R1's medication administration record (MAR) for December 2022, and January 2023, indicated the licensee started R1's Bactrim on January 2, 2023, 6 days after the antibiotic was ordered on December 27, 2022. There was no documentation the facility staff transcribed, scheduled, and/ or arranged for R1's X-ray. Review of R1's provider note dated January 3, 2023, indicated, "upon entering patient's room today, dressing was saturated". The note indicated staff changed R1's wet dressing. A MAARC (Minnesota Adult Abuse Reporting Center) report dated January 4, 2023, indicated facility staff failed to notify R1's provider when	02310		

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02310	Continued From page 3 they failed to administered R1's Bactrim for 10 days and the facility did not complete the X-ray which was ordered December 27, 2022. The home care nurse discovered the facility had not implemented the Bactrim or obtained the X-ray. The home care nurse contacted the physician and implemented the orders. A home care communication note dated January 9, 2023, indicated, "right foot lateral foot/toes not much improvement, no odor today. Wounds devitalized (lack of regeneration) tissue. Vital signs within normal limits, MRI tonight, surgeon Wednesday." There is no evidence the facility nursing staff observed R1's wounds. The licensee failed to provide wound assessments, documentation of the wound and wound condition, a service plan with any wound documentation, evidence of interventions in place to promote wound healing, and direction to staff to keep R1's wound clean and dry. During an interview on February 16, 2023, at 1:00 p.m., registered nurse (RN)-A stated she was aware R1 had provider orders from December 27, 2022, for Bactrim and an X-ray of R1's foot. RN-A stated the orders were not implemented until January 2, 2023. During a follow up interview on February 28, 2023, at 11:20 a.m., RN-A stated the facility was short of nursing staff so it was difficult to complete wound care, wound documentation, wound assessments, or medication reconciliation. RN-A stated the facility had no documentation of R1's wounds. The licensee's policy titled Skin Monitor policy	02310		

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02310	Continued From page 4 dated August 1, 2022, indicated the registered nurse is responsible for assessing each tenant's skin upon admission and when staff members or residents report skin changes. The policy indicated Cornerstone Communities do not care for complex wound needs and the nurse will notify provider to manage wound such as home health. The policy indicated the nurse will implement wound/pressure injury care once the orders have been obtained by adding them to the tenant's individualized plan of care and educating staff on care to be provided. The policy also indicated a licensed nurse is to assess the wound weekly unless otherwise instructed the tenant's physician by utilizing the "Weekly Wound Form" assessment or the "Weekly Wound Note" assessment in electronic record for documentation and should be completed until the wound has resolved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (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 one residents reviewed (R1) was free from maltreatment. Findings include:	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 5 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		