State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308383644M
Compliance #: HL308383993C

Date Concluded: August 16, 2024

Name, Address, and County of Licensee Investigated:
Lakewood Pines
1702 Airport Road NE
Staples, MN, 56479
Wadena County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 alleged perpetrator (AP) neglected the resident when the AP failed to inform the facility nurse of the resident's ankle wound. The resident had a stage 3 pressure injury requiring antibiotic treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The AP was not employed by the facility at the time the wound was discovered. The resident had a band aid on the resident's left ankle for at least two weeks upwards to a month without facility staff reporting the resident's wound to a nurse until the band aid peeled off. The resident was diagnosed with an ankle pressure injury and required antibiotic treatment and wound care.

The investigator conducted interviews with facility staff members, including administrative and nursing staff, and the AP. The investigation included review of the resident records, clinic

records, personnel file, and related facility policy and procedures. Also, the investigator observed the resident and the resident's wound care services.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure. The resident's service plan included assistance with bathing twice weekly which included skin checks and putting on and taking off ted (compression) stockings. Staff were directed to check the resident's skin during bathing and report any reddened or open areas to a nurse. The resident was oriented.

The resident's record indicated one day a nurse was alerted of a skin concern with the resident's left ankle. The resident had a pressure wound and there was concern for cellulitis (infection of skin.) That same day, an appointment was made at a clinic for an evaluation.

Clinic records indicated the resident was unsure when the wound first started, said "maybe" a month ago, and did not recall any injury. The resident wore compression stockings. The resident was diagnosed with a pressure injury of the ankle and started on antibiotics.

The resident's scheduled services indicated the resident received bathing assistance twice weekly and staff put on and took off the resident's compression stockings daily.

The AP's personnel record indicated the AP had not worked at the facility for a time frame exceeding two weeks before the resident's ankle wound was assessed.

During an interview, the AP denied knowledge of the resident's ankle wound or putting a band aid on the resident's ankle.

During an interview, a nurse stated one day a band aid on the resident's left ankle band had peeled off during a shower. That day, staff alerted the nurse of the resident's left ankle wound. The nurse stated the resident said the band aid had been on her ankle for at least two weeks upwards to a month. Facility unlicensed staff members provided bathing services twice weekly, as well as put on and took of the resident's compression stockings daily. The nurse stated no staff thought to remove the band aid during that time frame because the band aid was clean, dry, and intact. Facility staff did not alert a nurse the resident had a wound or had a band aid on her ankle until the day the band aid peeled off. The nurse stated the wound was a pressure ulcer and the resident had signs and symptoms of cellulitis. The resident was sent to a clinic for evaluation, received antibiotic treatment, and the facility provided the resident's wound care. The nurse stated it was an expectation for staff to alert a nurse of any observed changes with a resident's skin immediately.

During an interview, leadership stated the AP was not employed at the time when the resident's ankle wound was discovered. Facility staff did not report the resident's ankle wound until the day it was discovered in the shower. Leadership stated it was unknown when the band aid was applied. After this incident, the facility changed their processes including staff

notification to a nurse before a bandage was applied to a resident as well as staff dating and initialing the bandage.

During an interview, the resident stated at first her wound was a “mark” or “spot” like she had scratched it. The resident stated her wound was not “oozing” and facility staff put a band aid on it. The resident did not recall who applied the band aid.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility sent the resident in to be evaluated and educated staff on expectations of reporting changes with residents’ skin and expectations with bandage application. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Wadena County Attorney
Staples City Attorney
Staples Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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 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: #HL308383993C/#HL308383644M On July 16, 2024, 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 36 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL308383993C/#HL308383644M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) 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		