Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313363404M
Compliance #: HL313365604C

Date Concluded: August 8, 2023

Name, Address, and County of Licensee Investigated:

Caring Nurses
7700 Shingle Creek Drive
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 refused to provide wound care, neglected to provide bathing, declined to charge the resident's blood sugar monitoring device, and required a fingerstick for blood sugar monitoring. It was also alleged the facility neglected to communicate blood sugars and insulin with the provider.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided wound care as the resident allowed. The facility documentation indicated the resident received bathing unless the resident refused. The facility managed the resident's blood sugar monitoring device, charging, and changing it out per manufacturer's instructions when the resident had difficulty. The facility did not always receive provider requests for information, as the resident did not consistently share after visit information for unscheduled appointments.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager and care provider. The investigation included review of facility documents, incident reports, policies, and procedures related to wound care, skin care, blood sugar readings, treatments, and resident's rights. Also, the investigator observed staff interaction with residents.

The resident lived in an assisted living facility. The resident's diagnoses included depression, diabetes, and a below the knee amputation of the right leg. The resident's service plan included assistance with bathing, reminders for activities of daily living, medication administration, assistance with positioning, safety checks, skin care, transfers, monitoring of blood glucose levels, insulin management, and wound care. The resident's nursing assessment indicated the resident was alert, oriented, and their own decision maker. The assessment indicated the resident lacked insight into their diagnosis of diabetes, was not compliant with their diabetic diet, and was not compliant with foot cares.

During an interview, a nurse stated staff noticed one day the resident was bleeding on the bottom of their left foot when the resident returned from an independent outing. The nurse stated the resident did not know what happened, but thought they cut their foot while in the community. The nurse stated the resident went to the emergency department for treatment where they cleaned and dressed the wound. Podiatry recommended daily wound care/dressing changes for the resident's foot. The nurse stated she spoke with the resident and arranged a mutually agreed upon time for the daily wound care. The nurse stated the resident consistently left the facility prior to most scheduled wound care appointments.

The resident's hospital record indicated the resident presented to the emergency department several days later and stated the facility would not complete the wound care. The record indicated the facility arranged for skilled nursing to come to the facility to complete wound care three times per week (after one week they decided they were not able to provide the service, so the facility nurse again provided daily wound care). The resident's records indicated the resident visited the emergency department several more times with concerns stating the facility would not complete wound cares (failing to mention absences and refusals).

During investigative interviews, multiple staff members stated the resident was independent in the community and consistently left the facility when they had scheduled wound care. The staff stated the nurse talked to the resident to confirm the time for the wound care, but then the resident would leave. Staff stated the resident made independent choices and refused other cares at times, such as bathing and housekeeping.

During an interview a managerial staff stated the resident tried to manage their own blood sugar monitoring, but would forget to charge the sensor, so the facility managed blood sugars. The staff stated if the blood sugar monitoring device became dislodged or the scanner was not charged, the staff would do a fingerstick to monitor the resident's blood sugar, which could be for up to two weeks until the next device could be obtained. The managerial staff stated there

had been one request for the resident's blood sugars and insulin dosages, which they sent to the provider.

The resident's record indicated the facility nurse provided or attempted to provide wound care daily for the next three months until the wound completely healed.

The resident did not respond to requests to interview.

In conclusion, 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 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, the resident did not respond to requests for an interview.
Family/Responsible Party interviewed: No
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility had several meetings with the resident and case manager to arrange wound care appointments.

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
	31336	A. BUILDING: _____ B. WING _____	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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 August 2, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL313365604C/#HL313363404M. No correction orders are issued.	0 000		