Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31968011M
Compliance #: HL31968012C

Date Concluded: May 25, 2022

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living LLC
3030 Southlawn Drive
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit: The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Minors Act, Minn. Stat. 626.556, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s): It is alleged: The facility neglected the resident when facility staff failed to complete scheduled services.

It is alleged: The facility neglected the resident when facility staff failed to train unlicensed personnel on wound care before delegating that task. The resident's toe became necrotic and swollen.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. It is unknown if facility staff members failed to complete scheduled services on two separate occasions or if the resident refused the services. However, the facility neglected the resident when the facility did not train or competency test unlicensed personnel (ULP) before delegating wound care. The ULPs applied the dressing incorrectly and caused injury to the resident's toe.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator reviewed Minnesota Department of Health survey notes. The investigator also reviewed the resident record and employee files.

The resident's diagnoses included dementia, depression, and anxiety. The resident's service plan indicated the resident required assistance of one staff for all activities of daily living (ADLs) including dressing, grooming, bathing, and medication administration. The resident's service plan did not include wound care.

The resident's treatment plan/therapy management plan indicated the resident did not receive treatments such as wound care.

On the eighth day of the month, the resident's progress notes, indicated the hospice nurse trimmed the resident's toenails and cut the resident's fifth toe on the left foot. The same document indicated the resident's toenail lifted away from the toe and hospice ordered bacitracin to the affected toe until healed.

On the ninth day of the month, the resident's medication administration record (MAR) indicated an order for bacitracin to laceration on the resident's left fifth toe and cover with a bandage. The MAR did not include specific directions including what bandage to use or when to contact the registered nurse (RN). On the tenth day of the month, the resident's MAR indicated the ULP did not complete the dressing change. On the eleventh through the fourteenth day of the month, the resident's MAR indicated ULP#1 completed the wound care.

On the fourteenth day of the month, Minnesota Department of Health survey notes, indicated survey staff were in the hallway near the resident's room and heard the resident crying. The same document indicated the surveyor observed ULP#1 and ULP#2 assist the resident with cares. The same document indicated the surveyor observed a roll of Coban (self-adherent wrap) and a foam dressing on the resident's dresser. The ULPs said the hospice nurse instructed them to apply antibiotic ointment and Coban to the resident's toe.

The same day hospice notes indicated the resident's left toe was necrotic due to facility not following orders. The same document indicated the hospice RN notified the hospice medical doctor.

The same day the facility incident report indicated hospice staff removed the dressing to the resident's left fifth toe and the toe was black and swollen. The same document indicated the RN left the toe open to air and color returned to the toe.

On the fifteenth day of the month, the resident's progress notes indicated the resident's left pinkie toenail was black and covered in a fluid filled blister. The same document indicated the facility received for an order for an antibiotic and an X-ray. On the sixteenth day, the resident's

progress notes indicated hospice increased the resident's morphine. The progress notes also indicated the hospice RN will provide wound care treatment. The same document indicated the X-ray did not show an abnormality.

On the twenty fourth day of the month, the resident passed away. The Minnesota Document of Death record indicated the resident's cause of death was Alzheimer's disease. The record also indicated injury or trauma did not contribute to the cause of death.

ULP#1's employee record did not include training or competency testing for wound care.

ULP#2's entire employee record could not be located by the facility and did not include training or competency testing for wound care.

When interviewed, ULP#1 said she did not receive training for the resident's wound care and did not complete the wound care but did sign the service off as completed. ULP#1 said she asked other ULPs for assistance with the resident's services and assumed another ULP completed the wound care. ULP#1 said she watched ULP#2 change the dressing and apply the Coban one time in four days but did not remember what day. ULP#1 said the Coban was not tight.

When interviewed, the hospice RN said she was cutting the resident's toenails and noticed the resident's left fifth toenail had a laceration above the nail. The RN said she was able to lift the nail off the nailbed and appeared like the nail was going to fall off. The hospice RN informed the facility RN of the new wound care order and told the facility RN to put Band-Aids in the resident's room. The hospice RN said she did not have a Band-Aids, so she applied bacitracin, a gauzed pad and one loop of Coban to keep the gauze in place. The hospice RN said when she returned six days later, she removed the Coban off the resident's left fifth toe and the toe was black and cold. The RN said color did return to the lower portion of the toe, but the top of the toe and edges of the nail bed were "dark, if not black." The RN said the Coban was tight and wrapped around the resident's toe four times.

When interviewed, the facility RN said she did not train the ULPs to complete the resident's wound care. The RN also said the hospice RN used bandage and band aide interchangeably when describing the wound care order. The RN said she gave Band-Aids to the ULP to put in the resident's room. The RN said she should have called hospice to clarify the order. The RN also said she was not aware the hospice RN left Coban in the resident's room. The RN also said the facility was unable to determine when the ULPs changed the dressing.

When interviewed, the director of nurses (DON) said when there is a new treatment delegated to ULPs, the RN would have to train, and assess the competency of the ULPs. The RN would also have to ensure the correct supplies were in place and ensure the resident's service plan included the treatment.

In conclusion, 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" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable

Action taken by facility:
ULP#1, ULP#2 are no longer employed 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, or call

651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	C 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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 Initial comments 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: #HL31968010C/#HL31968009M #HL31968012C/#HL31968011M On May 25, 2022, 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 50 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL31968012C/#HL31968011M, tag identification 2360.	0 000	The Minnesota Department of Health documents 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 state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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: Based on interviews, and document review, the facility failed to ensure one of one residents (R1) was free from maltreatment. R1 was neglected. Findings include: On May 25, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	