DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324372180M
Compliance #: HL324371123

Date Concluded: August 25, 2024

Name, Address, and County of Licensee Investigated:
Oak Terrace Le Seur
811 South 4th Street
Le Sueur, MN
Le Seur County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator
Reconsideration Analyst: Jacci Nickell

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 the resident was admitted to the hospital with an unstageable coccyx (tailbone) wound.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not ~~substantiated.~~ ~~The facility was responsible for the maltreatment.~~ The resident was admitted to the hospital with an unstageable pressure ulcer on her coccyx. The facility denied having any prior knowledge of the pressure injury before the resident's hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.
The resident resided in an assisted living facility. The resident's diagnoses heart failure and muscle weakness. The resident's service plan included assistance from one person for bed mobility and two persons with a Sara Steady [partial assist mechanical lift] for all transfers.

According to the assessment three months prior to the incident, the resident was at risk for skin breakdown and had no active wounds. The same document indicated facility provided assistance with a shower scheduled once a week.

One day, the resident complained of shortness of breath and was admitted to the hospital due to fluid overload. During this hospitalization, the resident was found to have an unstageable pressure ulcer [a type of pressure ulcer which occurs when prolonged pressure on the skin cuts off blood flow and oxygen to the tissue] on her coccyx and her left heel.

Hospital records indicated the wound on the resident's coccyx had necrotic [dead] tissue, and the depth was unclear. The same records indicated the wound had a foul smell and yellow drainage. Additionally, the hospital identified a pressure wound on her left heel.

The progress notes indicated the facility was unaware of the wound until the hospital provided notification of it.

During an interview, a manager stated she did not know about the wound until the hospital called. The manager said before the resident's hospitalization, the resident would call if she needed to change positions. After her hospitalization, the resident was placed on a schedule of repositioning every two hours. The manager also stated that she performed a basic skin assessment during admission and the facility only conducts skin assessments when a resident has a concern about their skin.

During an interview, a nurse stated the resident did not have the wound before she went to the hospital, or at least she was unaware of it. The nurse said the wound was present and open when the resident returned. According to the nurse, the facility's policy required staff to check the resident's skin on their shower day or whenever staff assist the resident with toileting.

In conclusion, the Minnesota Department of Health determined neglect was not 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. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
Le Seur County Attorney
Le Seur City Attorney
Le Seur Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32437	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE OF LE SUEUR LLC	**811 SOUTH 4TH STREET LE SUEUR, MN 56058**

(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 July 16, 2023, the Minnesota Department of Health initiated an investigation of complaint HL324372180M/HL324371123C . The following correction order is issued, tag identification 2310 and 2360.	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 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 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 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	02310		

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02310	Continued From page 1 (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 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide appropriate care and services for one of one resident (R1) reviewed. The licensee failed to implement an up-to-date individualized service plan following accepted health care standards for R1 who had a risk for skin breakdown. 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: R1 moved into the facility on August 28, 2023, due to diagnoses including heart failure and muscle weakness. R1's service plan no dated, indicated the resident needed assistance from one person for bed mobility and two persons with a Sara Steady (partial mechanical lift device) for all transfers. R1's assessment dated November 28, 2023, indicated the resident was at risk for skin breakdown and had no active wounds.	02310		

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02310	Continued From page 2 A hospital record dated February 8, 2024, indicated the wound on R1's coccyx had necrotic tissue, and the depth was unclear. There was no infection, but the wound had a foul smell and yellow drainage. Additionally, there was a pressure wound on R1 left heel. During an interview on July 31, 2024, at 10:29 a.m. Director of Nursing (DON) stated she did not know about the wound until the hospital called. She said before R1's hospitalization, R1 would call if she needed to change positions. After R1 hospitalization, R1 was on a schedule of repositioning every two hours. DON also stated the nurse performed a basic skin assessment during admission and that the facility only conducts skin assessments when a resident had a concern about their skin. During an interview on July 31, 2024, at 11:12 a.m. Licensed Practical Nurse (LPN) stated R1 did not have the wound before she went to the hospital, or at least LPN was unaware of it. She said the wound was present and open when R1 returned. According to LPN, the facility's policy required staff to check the resident's skin on their shower day or whenever staff assist the resident with toileting. 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.	02360		

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02360	Continued From page 3 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	Please see Public Report	