Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326477146M
Compliance #: HL326473642C

Date Concluded: March 4, 2024

Name, Address, and County of Licensee Investigated:
The Homestead at Rochester
5530 Ballington Rd NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

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 and the alleged perpetrator (AP) neglected the resident when the resident was not provided cares and she developed a wound on her right thigh.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did have a wound on her right leg, it was a recurring issue and not the result of neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of medical provider notes, service plan, assessments, wound assessment, and completed facility tasks. Also, the investigator observed staff to resident interaction, resident transfers, and ambulation with her walker.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, and diabetes. The resident's service plan included assistance of one staff for bathing/showers with skin monitoring and safety checks each shift. The resident ambulated independently with a walker and required verbal cueing from caregivers. The resident's assessment indicated she was forgetful.

The facility incident report indicated one morning the resident had a wound on the back of her thigh with black eschar (a thick, dry dead tissue from the surface of the skin). The same report indicated the wound may have been caused by the resident sitting on the toilet for a long period of time.

Written statements from unlicensed caregivers, who found the resident in the morning, indicated they found the resident sitting on the toilet sleeping. The resident stated she had been sitting there for a long time but could not provide any other information.

The resident's care plan indicated the resident used the bathroom independently and did have a history of sitting on the toilet for long periods of time. The resident's assessment indicated the resident was able to reposition herself.

The progress notes indicated the resident did have a history of wound development in the same area for the same reason.

The medical provider notes from a consultation two months prior to the incident indicated the resident had a wound in the same area on her right thigh and the facility was to encourage the resident not to spend extended periods of time sitting on the toilet.

During an interview, a nurse stated skin care checks are completed weekly during a shower or bath. The nurse stated the facility was aware of the resident's habit of sitting for lengthy periods of time on toilet and the right thigh wound was an ongoing issue, which did not occur overnight.

During an interview, a family stated the reported wound had been an ongoing problem even prior to admission. The family member stated the resident was able to stand and walk using her walker but had limited communication skills and could not report accurately. The family member stated the resident had a habit of going into bathroom in the middle of night and sit on the toilet for hours.

In conclusion, the Minnesota Department of Health determined 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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Declined

Action taken by facility:
No action required.

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
	32647	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(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 January 2, 2024 through January 3, 2024,, the Minnesota Department of Health initiated an investigation of complaint #HL326474723C/#HL326477809M, HL#326474716C/HL#326477864M and HL#326473642C/HL#326477146M. No correction orders are issued.	0 000		