Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL326818382M
Compliance Project: HL326815121C

Date Concluded: February 21, 2025

Name, Address, and County of Licensee Investigated:
River Oaks at Shady Ridge
225 Shady Ridge Road NW
Hutchinson, MN 55350
McLeod County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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 facility neglected the resident when he was found to have an unstageable wound on his coccyx, right foot, and left heel.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident developed wound on his right foot and left heel and the facility took appropriate steps for those wounds. However, the resident developed an unstageable pressure ulcer on his coccyx, which was not identified until an appointment with a wound clinic.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, personnel files, staff schedules, policies, and procedures.

The resident lived in an assisted living facility and had diagnoses of type 2 diabetes and abnormalities of gait and mobility. The resident's service plan included reminders to use the toilet and specified that the resident wore a pull-up during the day and a tab brief at night to manage incontinence. Caregivers were instructed to encourage the resident to use a urinal if he was unable to reach the bathroom. The service plan also indicated that the resident required assistance from one staff member for bathing. Additionally, staff were required to use a gait belt and walker when assisting the resident with transfers.

One day the resident was sent to the emergency room. The emergency department (ED) records indicated upon arrival the resident had a bowel movement-filled brief, with fecal matter leaking from both sides of the legs and up the back. Dried fecal matter was also present on the resident's back. The resident had scattered bruising on the body and was noted to be warm and dry. Additionally, there was superficial skin discoloration and a pressure injury on the left lateral thigh and buttock, as well as a separate stage II sacral pressure wound (a wound presenting as a shallow ulcer with a red or pink wound bed or like a blister).

A few days later, after the resident had returned to the facility, the assessment indicated the resident had itchy skin however it did not address the pressure ulcer identified at the hospital.

About two months later, the resident developed a wound on his right foot attributed to placement of his foot against the footboard of his bed. A few days after that the identified another wound on his left heel. The facility made arrangements for the resident to be seen at a wound clinic.

About a week later at the wound clinic the resident was identified with a third wound: an unstageable (a wound bed which is not visible due to a thick layer of dead tissue) wound located on his left buttocks/coccyx, which had not been previously identified.

During an interview, a case manager stated that she accompanied him to his wound clinic appointment and learned about his wounds. The case manager stated he had a wound on his left heel and another on his right foot. Additionally, the clinic staff member checked his coccyx and found a wound there as well. She said the provider at the wound clinic told her about the wound on his left heel had been present for a couple of months. It was black, and the clinic had decided not to intervene. The wound on his right foot became an open wound as well. However, the case manager was unsure when it initially developed. This was the first wound clinic appointment she attended with him. She said the provider at the clinic said that his coccyx wound had been noted in the ER a few months back.

During an interview, unlicensed caregiver #1 stated that she had worked with the resident for a while and knew him well. She said she noticed the wound on his right foot at the end of December, and a staff member informed her about his coccyx wound a week later. She stated that he began treatment at the wound clinic on the same day she learned about the coccyx wound. However, she was unaware of the wound on his left heel.

During an interview, the manager, who is a nurse, stated that the first time she became aware of the resident's foot injury was when he contracted COVID-19 at the end of December. She said the resident kicked the bottom of his bed, causing an open wound on his right foot. She also said that when she checked on him the following day, she noticed a wound on his left heel. After inquiring with staff members, she found that no one was aware of it. She stated that the wound on his left heel was likely caused by prolonged periods of bed rest. She became aware of his coccyx wound a week later, at which point it was already open.

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: No.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The resident was seen at the wound clinic when the facility found out about the wounds.

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
McLeod County Attorney
Hutchinson City Attorney
Hutchinson Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32681	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT SHADY RIDGE LLC	225 SHADY RIDGE ROAD NW HUTCHINSON, MN 55350

(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 22, 2025, the Minnesota Department of Health initiated an investigation of complaint HL326818382M/HL326815121C. The following correction orders are issued 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 record review, the licensee failed to provide appropriate care and services according to an up-to-date service plan and accepted health care standards for one of one resident's (R1). After R1 returned from an emergency room visit where a stage two pressure ulcer was identified, the facility failed to assess R1's wound. Later R1 developed an unstageable wound that was not identified until during an appointment at a wound clinic. 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). Findings include: R1's diagnoses included type 2 diabetes mellitus, prior alcohol/drug abuse, chronic hepatitis-C, rheumatoid arthritis, hypertension, and hyperlipidemia. R1's service plan, effective dated August 16, 2021, indicated R1 required the assistance of one person with bathing twice a week, continence care, housekeeping, and medication	02310		

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02310	Continued From page 2 management. R1's service received report from September 2, 2024, to January 20, 2025, indicated that R1 had showered five times. The report also noted that the resident refused to be showered the rest of the time. Some dates were left empty without notes from staff. A review of R1's progress notes from September 3, 2024 to January 17, 2025, did not identify documentation regarding R1's refusal of bathing. Review of R1's base line nursing assessment dated October 14, 2024, was completed by Director of Nursing (DON)-E, indicated skin was intact, no concerns. R1's emergency room record dated November 1, 2024, indicated R1 transferred to the emergency room for evaluation of abdominal pain and leg pain. The same documents indicated upon arrival R1 had a bowel movement-filled brief, with fecal matter leaking from both sides of the legs and up the back. Dried fecal matter was also present on the resident's back. R1 had scattered bruising on the body and was noted to be warm and dry. Additionally, there was superficial skin discoloration and a pressure injury on the left lateral thigh and buttock, as well as a separate stage II sacral pressure wound. The resident returned to the facility the same day. R1's change in condition nursing assessment dated November 4, 2024, was completed by (DON)-E, indicated skin was "itching" to the "skin integrity" part. The same document did not include identification of skin concerns nor the presence of a pressure ulcer.	02310		

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02310	Continued From page 3 A progress note dated December 30, 2024 indicated the facility identified a wound on the resident right foot attributed to the placement of his foot against the footboard of his bed. A service plan updated December 30, 2024 indicated the caregivers were to assist R1 reposition in bed to prevent skin break down and reference wounds to feet and on bottom. A Braden Scale assessment date December 31, 2024, indicated the facility assessed the resident with a score of 14 points which indicated moderate risk. A progress note dated January 2, 2025, indicated the facility provided cares to the resident's right foot and identified a wound on his left heel. A wound clinic document indicated the resident had an appointment on January 6, 2025, during which three wounds were addressed. The wound clinic addressed both the right and left foot previously identified by the facility, however the wound clinic identified a third wound as an unstageable pressure ulcer located on his left buttock. A progress note dated January 7, 2025 indicated the resident had three wounds and home care services were being set up for treatment. The same document described the location of the wounds as the left foot, the right foot, and the resident's coccyx. Although the facility added repositioning to the care plan on December 30, 2024, when the documentation for this intervention was requested, the document provided by the facility did not include it nor did it document refusal of repositioning by R1. A review of R1's medical	02310		

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02310	Continued From page 4 record between found no documentation the facility was alerted regarding the unstageable wound identified by the wound clinic on January 7, 2025. During an interview on January 22, 2025, at 2:44 p.m., a case manager (CM)-A stated she accompanied R1 to his wound clinic appointment and learned about R1's wounds. (CM)-A said that R1 had a wound on his left heel and another on his right foot. Additionally, the clinic staff member checked R1 coccyx and found a wound there as well. (CM)-A said the provider at the wound clinic told her about the wound on his left heel had been present for a couple of months. It was black, and the clinic had decided not to intervene. The wound on his right foot became an open wound as well. However, (CM)-A was unsure when it initially developed. This was the first wound clinic appointment she attended with R1. (CM)-A said the provider at the clinic said that R1's coccyx wound had been noted in the ER a few months back. During an interview on February 4, 2025, at 8:00 a.m., (DON)-E stated that the first time she became aware of R1's foot injury was when he contracted COVID-19 on December 30, 2024. She said R1 kicked the bottom of his bed, causing an open wound on his right foot. She also said that when she checked on him on January 2, 2025, she noticed a wound on his left heel. After inquiring with staff members, she found that no one was aware of it. She stated that the wound on his left heel was likely caused by prolonged periods of bed rest. She became aware of his coccyx wound on January 5, 2025, at which point it was already open. During an interview on February 6, 2025, at 5:18	02310		

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02310	Continued From page 5 p.m., the unlicensed personnel (ULP)-G stated that R1 had a wound on his bottom when she started working in September 2024. She said that when the staff members changed his brief, they were instructed to apply cream, ensure he was clean during incontinence care, and be gentle with the area. During an interview on February 7, 2025, at 8:48 a.m., the unlicensed personnel (ULP)-H stated that she had worked with R1 for a while and knew him well. She said she noticed the wound on his right foot on December 30, 2024, and a staff member informed her about his coccyx wound on January 6, 2025. She stated that R1 began treatment at the wound clinic on the same day she learned about his coccyx wound. However, she was unaware of the wound on his left heel. 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. 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	02360	No plan of correction is required for this tag.	

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02360	Continued From page 6 maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		