Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL332712803M
Compliance #: HL332714679C

Date Concluded: July 27, 2023

Name, Address, and County of Licensee Investigated:
The Legacy of Farmington
22300 Denmark Avenue
Farmington, Minnesota 55024
Dakota County

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

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Inconclusive

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 a resident when the facility failed to ensure the resident's compression stockings used for treating lower leg lymphedema were applied as ordered. The resident experienced a fall due to not having her compression stockings applied.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident stated staff did not assist her with applying her compression stockings. Facility documentation indicated staff assisted the resident with applying the stockings unless the resident refused or was out of the building. It could not be determined the resident had a fall related to staff failing to apply the residents compression stockings.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and supportive service staff. The investigation included review of

medical records, policies, and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility and was her own decision maker. The resident's diagnoses included lymphedema and fibromyalgia. The resident's service plan included daily compression stocking application and removal, assistance with medication patch, bathing, dressing, and grooming. The resident's assessment indicated she was cognitively intact, able to make needs known, resistive to cares at times, had difficulty coping with delays, and was able to move about freely with or without an assistive device.

Review of care documentation from staff members the three weeks prior to the incident indicated staff members documented the resident's refusal of compression stocking application five times. Care documentation also indicated compression stockings were not applied to the resident the day prior to the incident due to the resident being out of the building.

Review of resident progress notes during the time in question indicated the resident called emergency services to go to the hospital and informed the facility receptionist her leg was swelling too much. The note indicated the resident came to the lobby at 9:30 A.M. and reported to the receptionist staff did not apply her compression stockings which was scheduled at 6:00 A.M. The note indicated the nurse was unable to assess the resident prior to the resident leaving for the hospital.

During an interview, the resident stated she had lymphedema and wore custom made compression stockings daily to prevent swelling. The resident stated she could not be out of bed without her stockings because she was prone to infections due to lymph fluid being in her legs and because the weight of the extra fluid in her legs makes it harder to walk. The resident stated staff were to assist her daily with application and removal of the stockings, but staff would come before she was ready to get out of bed or not come at all to assist her with stocking application. On other occasions, staff would erroneously document that she refused the service or that staff applied her stockings when they did not. The resident stated during the time in question staff had not assisted with her stockings and due to the fluid buildup in her legs, she lost her balance, fell, and needed to go to the hospital.

During an interview, a nurse stated during the time in question the resident would occasionally decline compression stocking application services or request staff assistance at specific times when staff were not available due getting oncoming report, passing medications, or tending to other residents' priority needs such as blood sugar checks. The nurse stated she was not aware of staff members refusing to apply the residents' stockings.

During an interview, a second nurse stated the resident typically walked independently, drove herself to appointments, spent time out in the community, and used a walker as she needed. The second nurse stated the resident self-reported falls that were not witnessed by staff members, and the resident did have days when she felt weaker.

During an interview, an unlicensed personnel member stated the resident would decline stocking application if the service could not be completed at a specific time or if the resident was feeling ill and laying in bed. The unlicensed personnel member stated she would only document service refusal if the resident declined the service and denied falsely documenting resident service refusals.

During an interview, a support services worker stated the resident made her aware of occasions when facility staff members did not apply the resident's compression stockings and additional requests were made by the support services worker to have the stockings applied. The support services worker stated there were times when the resident did not have her stockings applied, but she could not say if that was due to the resident declining the service or if the staff members failed to offer to apply the stockings.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, Vulnerable adult was own decision maker.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted internal review of incident and allegation.

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
	33271	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF FARMINGTON	22300 DENMARK AVENUE FARMINGTON, MN 55024

(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 June 27, 2023, the Minnesota Department of Health initiated an investigation of complaint HL332714679C/HL332712803M. No correction orders are issued.	0 000		