Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348753961M
Compliance #: HL348754464C

Date Concluded: August 26, 2024

Name, Address, and County of Licensee Investigated:
Talamore Senior Living
215 37th Ave. North
St. Cloud, MN 56303
Stearns County

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

Evaluator's Name: Brooke Anderson, 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 the resident was hospitalized with a large open wound on her buttocks, the resident became septic (a life-threatening condition caused by a severe localized or system-wide infection) and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to assess, monitor, and implement physician orders to promote healing and/or prevent worsening of the resident's wounds. The wound required surgical debridement, intravenous (IV) antibiotics, and a wound vacuum for treatment. The resident was hospitalized and died nine days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted outside agency hospice staff. The investigation included review of resident records, a death record, hospital records, facility

incident reports, personnel files, staff schedules, and related facility policies and procedures. At the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease. The resident's service plan included assistance with turning and repositioning, wound care, and medication management. The resident's assessment indicated she had mild disorientation to person, place, or time and was receiving hospice care.

The medical record indicated the resident's buttocks was reddened, inflamed, and became an open wound. Over the course of five months, wound care orders changed approximately seven times. The facility failed to implement the orders as prescribed. The medical record indicated facility unlicensed staff completed the wound care and had concerns on which wound care order was supposed to be completed. The facility failed to train the unlicensed personnel on how to complete the wound care. Turning and repositioning was ordered by a physician, and there were conflicting accounts on if the turning and repositioning was completed. The resident's medical record indicated nursing assessments were not routinely completed by facility nurses. The wound progressively worsened, and the unlicensed staff updated the hospice team and facility nurses about their concerns with the wound's progression. The response provided to unlicensed staff was that the wound was not likely to heal, and aggressive treatment would not be initiated; the goal for the resident included comfort and pain management with the use of prescribed pain medications.

While attending an appointment at an outside clinic, the resident's physician noted the resident had increased lethargy and sent the resident to the emergency room for further evaluation. Emergency room records indicated the resident had a large pressure ulcer that was 6.5 cm in length, 7.2 cm in width, and 3.2 cm in depth. The wound had signs of infection and an odor. The resident was placed on intravenous (IV) antibiotics, the wound was surgically debrided (the removal of damaged tissue), and a wound vacuum device was initiated. Hospital records indicated the resident was septic (systemic infection) from the wound and died nine days later. The death report indicated the resident died from acute hypoxic respiratory failure due to sepsis.

During investigative interviews, multiple unlicensed staff stated the resident had a wound that progressively worsened. Unlicensed staff reported to facility nurses that the resident was not being turned and repositioned as ordered. Unlicensed staff stated the facility did not train them on how to complete the resident's wound care until after the resident died. Staff reported the wound looked infected and had a strong odor, but they never saw a facility nurse assess the wound and were told hospice would take care of it. The unlicensed staff stated more should have been done for the resident.

During an interview, a facility nurse stated the wound started as a small pressure ulcer and the facility implemented every two-hour repositioning and tried different wound treatments. The

nurse recalled that the wound would get better than would get worse. The facility nurse stated wound assessments she completed were occasionally based off the hospice nurse's assessment if she couldn't assess it herself. The facility nurse stated because the resident was on hospice the goal wasn't to heal the wound but to keep her comfortable.

During an interview, a hospice nurse stated the wound was initially superficial and irritated and quickly developed into a pressure ulcer. The hospice nurse stated the wound worsened despite treatments ordered by the provider. The hospice nurse was not sure if turning and repositioning was completed by staff as ordered. The hospice nurse stated prior to the resident's hospitalization she completed visits twice per week and although the wound was worsening and had an odor, an antibiotic was not started because hospice didn't offer aggressive treatments like antibiotics.

During an interview, a family member stated he was told the resident had a bruise on her back and that it was being taken care of. The family member couldn't imagine the pain the resident went through with the wound and although hospice kept increasing the medication, the medication just made the resident more and more lethargic. The family member stated if he would have been told about the severity of the wound, he would have had her sent to the emergency room for treatment.

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: Yes.
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
Stearns County Attorney
St. Cloud City Attorney
St. Cloud Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	R-C 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37TH AVENUE NORTH SAINT CLOUD, MN 56303

(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 October 21, 2024, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint #HL348754464C/#HL348753961M. The following correction order is re-issued for #HL348754464C/#HL348753961M, tag identification 2320.	{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	

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{0 000}	Continued From page 1	{0 000}	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{02320} SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure healthcare and assisted living services were provided by people who were properly trained and competent to perform their duties, when unlicensed staff were not trained or educated on how to perform wound care for one of one resident (R2). This resulted in wound care not being completed per physician orders. In addition, the unlicensed staff did not follow infection control standards while completing wound care. 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:	{02320}		

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{02320}	Continued From page 2 R2's diagnoses included Alzheimer's disease and type 2 diabetes mellitus. R2's service plan dated October 21, 2024, indicated R2 received assistance with wound care. R2's physician's orders dated October 19, 2024, indicated wound care was to be completed to R2's right lower extremity. R2's wound care orders included: wound was to be cleansed with wound cleanser, pat dry gently with gauze pads. Then cut an absorptive dressing to fit R2's wound bed, place the absorptive dressing onto a foam boarder dressing. Then apply layer of crushed Flagyl (antibiotic) to absorptive dressing. Apply foam border, absorptive dressing and Flagyl to wound. The orders indicated for the dressing to be changed every two to three days and as needed if the dressing is soiled or falling off. Hospice registered nurse to change routine and the facility to complete as needed. During an interview on October 21, 2024, at 11:40 a.m. unlicensed personnel (ULP)-B stated R2's wound care was supposed to be managed by nursing but if R2's wound needed a dressing change, then the ULPs completed it. ULP-B stated the wound care supplies were in R2's room. ULP-B stated staff were trained on basic wound care but not trained specifically on how to provide R2's wound care. During an interview on October 21, 2024, at 11:46 a.m. ULP-C stated no wound care training was completed since the last time the Department of Health made a visit. ULP-C stated ULPs are no longer supposed to do wound care. ULP-C stated that last evening ULP-A told the nurse that R2's	{02320}		

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{02320}	Continued From page 3 wound dressing was soiled. ULP-A ended up having to change R2's wound dressing herself. During an interview on October 21, 2024, at 11:49 a.m. ULP-A stated R2's wound was nasty, infected, and green. ULP-A stated the nurses don't care and don't check on R2's wound. ULP-A stated, "I don't even know if we are supposed to or are allowed to change the wound care, but I do it because it is nasty, and they don't seem to care." ULP-A stated she was not trained on how to perform R2's wound care treatment. During an observation on October 21, 2024, at 1:30 p.m., unlicensed personnel (ULP)-A and ULP-B were in R2's room providing incontinence care. After providing incontinence care, ULP-A and ULP-B removed their gloves. ULP-A and ULP-B indicated R2's wound was on her right lower extremity. ULP-A stated, she unwraps the ace wraps and looks at the wound a couple times a shift. ULP-A stated she did this because she was so concerned about the wound. ULP-A then unwrapped the ace wraps and removed the wound dressing in front of the investigator. ULP-A did not have gloves on and had not completed hand hygiene after providing R2's incontinence care. ULP-A cleansed the wound with wound cleanser and R2 moaned in pain. ULP-A began to complete wound care to R2's wound. ULP-A applied a gauze pad and a border dressing to R2's wound. R2 grimaced throughout the wound dressing change and was red in color. ULP-B stated R2 was given a morphine approximately 30 minutes prior. ULP-A and ULP-B both stated R2's wound causes R2 pain. During an interview on October 21, 2024, at 2:14 p.m. the director of nursing (DON) stated the facility audited who was on hospice and who had	{02320}		

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{02320}	Continued From page 4 wounds and developed a plan to look in their charts to ensure physician orders matched the treatment administration record. The DON stated they met with hospice nurses to collaborate cares; however, she did not take any notes of the meetings. The DON stated ULPs were educated to no longer complete wound care on the residents. The DON stated she was not aware hospice showed ULPs how to do wound care and was not aware staff were completing wound care. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration Policy, dated July 28, 2021, indicated before the RN delegates the task of assistance with treatment and therapy the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. No further information was provided.	{02320}		