Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354211681M
Compliance #: HL354213271C

Date Concluded: January 24, 2023

Name, Address, and County of Licensee Investigated:
Benedictine Living Community of Northfield
2030 North Avenue
Northfield, Minnesota 55057
Dakota County

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

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

Finding: Not Substantiated

Nature of Visit:
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 provide appropriate repositioning and pressure relief for the resident's skin which resulted in a pressure injury to her leg.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided repositioning and care according to the resident individualized needs and as discussed with the resident's family members to ensure the residents comfort during end of life.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of staff records, medical records, and policies and procedures. Also, the investigator observed staff members providing care to residents at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease and chronic swelling. The resident's service plan included assistance with compression stocking application and removal, bathing, toileting, meals, medication management, and mobility assistance. The resident's assessment indicated she was at high risk for skin pressure injuries.

The resident's hospice notes indicated the resident's legs were swollen and her skin was very thin. During the time in question, the resident was experiencing uncontrolled pain that would increase with movement. Hospice documentation four days prior to the resident's death indicated even the slightest touch made the resident wince and call out in pain. Pain medication changes were made to reduce the resident's pain and make it more comfortable to be repositioned.

During an interview, a nurse stated the resident had a history of ongoing skin ulcers. The nurse stated during the last week of the resident's life, the resident developed a wound to her lower leg that was likely due to supporting the resident's leg with towels which caused pressure and the resident not being repositioned every two hours.

During an interview, a second nurse stated the resident had lower leg swelling, skin discoloration, and chronic fluid filled blisters. The second nurse stated during the resident's last month of life, she experienced increased pain with movement and a repositioning schedule was created with the input of the resident's family. The resident was to be turned every three hours except for a twelve-hour period at night when she would not be repositioned. The nurse stated the resident was on an air mattress and repositioned with pillows to help skin integrity and comfort. The resident developed a lower leg wound during her end-of-life timeframe that appeared as a scabbed bruise, and the resident also had multiple scabs to her legs during the time in question.

During an interview, a family member of the resident stated the resident had a history of severe swelling in her legs and was treated for skin ulcers for more than a year. The family member stated the resident often chose to sit or sleep in a chair, which put more swelling and pressure on her skin ulcers. The family member stated the priority during the resident's end of life was pain management and her "paper thin" skin would often tear and open. The family member stated he visited the resident most days of the week and did not have concerns regarding care of the resident's skin and wounds.

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, deceased
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:
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
	35421	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY N	2030 NORTH AVENUE NORTHFIELD, MN 55057

(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 December 7, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL354213271C/#HL354211681M. No correction orders are issued.	0 000		