Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359881280M
Compliance #: HL359888703C

Date Concluded: August 13, 2024

Name, Address, and County of Licensee Investigated:
Noah Home Care
13521 Nicollet Lane
Burnsville, MN
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katie Germann, 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 neglected a resident when facility staff did not provide appropriate wound care for the wounds on both of the resident's legs and right foot, causing the resident to be hospitalized with cellulitis (a bacterial infection of the skin).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had vascular wounds (skin sores caused by poor blood circulation) on both legs, his left great toe, and was hospitalized due cellulitis. The resident had a history of retaining fluid in his lower extremities which resulted in draining blisters. The facility assessed, monitored, and provided care to the resident's vascular wounds according to physician orders.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, hospital records, facility policies and procedures, and employee training. The investigator

contacted the wound clinic registered nurse, Also, the investigator observed the resident's wounds and home care staff providing wound care.

The resident resided in an assisted living facility. The resident's diagnoses included cognitive impairment, congestive heart failure, and venous wounds (wounds caused by impaired blood circulation). The resident's service plan included assistance with bathing, dressing, grooming, medication administration, meals, and wound care. The resident's assessment indicated the resident had wounds to his left leg and foot that were managed by the facility nurse.

An outside report indicated the resident had wounds on both of his lower legs and his left foot due to increased swelling in his lower legs and feet. The wounds were open and draining fluid. The report indicated the resident had provider orders for wound dressing changes 3-5 times per week. The report indicated the wound dressings had appeared to not have been changed between wound care appointments at an outpatient clinic.

Wound care notes indicated the wound clinic staff were unable to get "verifiable" information from the resident regarding the facility staff capabilities in providing his wound cares. The wound clinic notes indicated the resident would have home care nursing assisting with wound care at the facility.

Facility nursing progress notes indicated the facility nurse was monitoring the wound weekly between wound clinic appointments. The nursing notes indicated on one occasion the facility nurse took the resident to the emergency room, where the hospital staff checked and cleaned the resident's wounds and redressed them. The resident was discharged and sent back to the facility. The notes indicated the resident got orders from the hospital for home care nursing to come and manage the resident's wounds. The notes indicated 13 days after the first hospitalization, the home care nurse came to redress the resident's wounds and the resident was complaining of pain. The resident was sent to the emergency room, where he received Keflex (an antibiotic medication) and discharged back to the facility.

Hospital notes indicated the resident had two hospitalizations within 13 days. The first hospitalization was due to increased swelling and redness in both of his lower legs. The hospital notes indicated the resident did not have an infection in his lower legs and attributed the increased swelling in his legs to potentially the resident not following the water restriction required to manage his congestive heart failure. The resident returned to the hospital a week later, due to the resident reporting increased pain, swelling, and redness in his lower legs. The resident had cellulitis in his lower legs or "possible chronic lymphedema" (swelling caused by a lymphatic system blockage). The hospital notes indicate the resident was treated in the Emergency room and discharged back to the facility.

The resident's treatment plan indicated the resident received wound care from the facility as needed. The registered nurse would monitor and supervise wound care, administer wound dressings and update the provider on wound status.

The resident's service recap indicated the resident received 20 minutes of wound care by facility staff every other day leading up to his first hospitalization.

In a document titled, "service detail changes", there were documented wound care orders for the resident. The orders gave instruction on wound care and indicated wound care was to be provided by the day shift staff and wound care needed to be completed three days per week on Tuesday, Friday, and Sunday.

When interviewed, a facility nurse stated the resident's wounds began as blisters on his left foot, had increased swelling in his lower legs, and the resident developed blisters that started at the residents' feet and went up his legs. The resident's physician ordered furosemide (a diuretic medication). The nurse stated an outside wound agency assisted with wound care, and he trained the facility staff how to complete the residents' dressing changes.

During an interview, the resident stated he is happy in the facility, and feels his wounds are being cared for.

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: Yes
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
	35988	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH HOME CARE INC	13521 NICOLLET LANE BURNSVILLE, MN 55337

(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 May 28, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL359888703C/#HL359881280M. No correction orders are issued.	0 000		