*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL364132182M
**Compliance #:** HL364133798C

**Date Concluded:** February 28, 2023

**Name, Address, and County of Licensee Investigated:**
Benedictine Living Community
1705 Windermere Way
Shakopee, MN 55379
Scott County

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

**Evaluator's Name:**
Maerin Rene, 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 a resident when the resident developed a sacral pressure ulcer and necrotic tissue on his fingers, toes, and penis. The resident subsequently 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 ensure appropriate monitoring and oversight for the residents wound care. Although an external home care agency was referred to provide wound management services to the resident, the home care agency never opened the resident to services. The facility did not oversee wound management services to ensure the resident's wound care was being managed, nor were updated assessments of the resident's wounds and skin completed by the facility. The resident was hospitalized and died.

The investigation included interviews with facility staff including administrative, nursing, and unlicensed staff. The investigator contacted home care and hospital staff. The investigation

included review of the resident's medical, home care, and hospital records. Also, the investigator observed resident cares.

The resident resided in an assisted living facility. The resident's diagnoses included non-healing ulcer of multiple sites of lower extremity, necrosis of tip of penis, necrosis of tip of finger, end stage renal disease, and diabetes type 2. The resident's service plan included assistance with dressing, grooming, bathroom assistance, special needs care, general mobility, and medication management.

Upon admission to the facility, the resident's physician ordered a home care agency to provide wound care three times a week. The facility staff were directed to provide "simple" wound care to the resident's necrotic penis. The resident's facility assessment indicated staff were to verify treatment and therapy was administered as prescribed, and to monitor treatments or therapy to prevent possible complications or adverse reactions. The specific treatments or therapies were not named.

The resident's facility medical record contained no assessment of the resident's skin, and no documentation of wound measurements, locations, type, or how many wounds the resident had upon admission to the facility.

The resident's facility medication administration record (MAR) indicated wound care was completed by a home care agency three times weekly. However, there was no description of which wound(s) the home care agency was/were managing. There was no documentation the wound care was being provided by the home care agency.

The following month, the residents MAR again indicated wound care was performed by a home care agency three times weekly. There was no documentation the wound care was provided by the home care agency.
An updated order written on the residents MAR 6 days prior to his death directed staff to change the resident's bandage on his lower right leg every three days, and as needed. There was no documentation regarding staff providing any care to the wounds on the resident's right lower leg.

Review of resident medical records indicated a home care agency nurse went to see the resident shortly after the resident was admitted to the facility. However, home care did not open the resident to home care services as the resident was referred to hospice (end of life cares).
The resident's medical record lacked any further documentation of the residents' wounds, ongoing assessments, notification to the physician regarding the resident not receiving wound care, and specific direction to staff regarding interventions to prevent worsening of the wounds.

The resident's facility progress note dated 21 days after admission indicated the resident's family member was contacted by the residents outside dialysis clinic and reported the resident had feces all over and was not clean. The resident's family member requested the clinic send the resident to the hospital.

The resident's hospital record from that day indicated the resident had non-healing ulcer of multiple sites of the lower extremity, and active problems of necrosis of the tip of the penis, and necrosis of finger. Upon physical examination, open wounds, ulcers, and scabbed areas to multiple places on the resident's bilateral upper extremities (BUE) and bilateral lower extremities (BLE) were noted. The resident's index finger looked necrotic, with dusky or nonviable fingers involving his fourth and fifth fingers of the left hand. The resident's lower extremities revealed partial desquamation (shedding of skin) and open wounds of both great toes. The wounds were described at bleeding and painful. The resident also appeared to have stool on the bottom of his feet, and dried feces were noted on the resident's buttocks, groin, and thighs. The hospital notes indicated the resident's living condition was "suboptimal", and he "deserved better care of his wounds." The resident died in the hospital several hours after arriving.

The resident's death record indicated the cause of death was non-healing ulcers of multiple sites of lower extremity.

During interview a facility nurse stated she did not know if facility nurses provided wound care for the resident. The nurse was aware the resident had wounds, but she had never seen them. The nurse stated the resident wounds were managed solely by a home care agency and the agency assumed full responsibility for wound management. The facility did not maintain wound care records.

When interviewed a home care agency nurse stated the resident did not receive homecare services for wound care because the resident was referred to hospice services.  Shortly after, the agency was then notified the resident declined to enroll in hospice. When a home care nurse returned to the facility to discuss services with the resident, the resident declined home care. The nurse confirmed the resident was never opened to services with the home care agency, and never received wound care from the home care agency. There was no documentation from the facility to indicate the resident's physician was notified regarding wound care not being completed.

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, deceased.
**Family/Responsible Party interviewed**: No, declined interview.
**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
Scott County Attorney
Shakopee City Attorney
Shakopee Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36413 | A. BUILDING: _____ B. WING _____ | C 01/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE LIVING COMMUNITY | 1705 WINDERMERE WAY SHAKOPEE, MN 55379 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL364133798C/#HL364132182M<br><br>On January 12, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 63 residents receiving services under the providers Assisted Living with Dementia Care license.<br><br>The following correction orders are issued for #H364133798C/#HL364132182M, tag identification 2310 and 2360. | 0 000 | Minnesota Department of Health is documenting the State Licensing 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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=J | 144G.91 Subd. 4 (a) Appropriate care and services | 02310 | | |

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| 02310 | Continued From page 1<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure appropriate care and services were provided to 1 of 1 resident, R1, reviewed for staff services provided. The facility failed to assess R1's skin and wounds and failed to provide oversight to determine the individualized plan of care ensured staff provided appropriate care and services.<br><br>This practice resulted in a level four violation (a violation that results in 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).<br><br>Findings include:<br><br>R1 was admitted to the facility June 21, 2022. R1's service plan dated June 21, 2022, indicated R1 required assistance with dressing, grooming, bathroom assistance, special needs care, general mobility, and medication management.<br><br>R1's facility assessment, dated June 21, 2022, and integrated into the service plan, indicated staff were to provide wound care: "daily dressing changes, wound, measuring, application of ointment/creams. Cleaning and ointment twice daily to penis as described in the MAR (medication administration record) orders. Update | 02310 | | |

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| 02310 | Continued From page 2<br>nursing/provider with worsening skin issues."<br><br>R1's treatment and therapy assessment dated June 21, 2022, and integrated into the service plan, indicated any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions would be provided by staff.<br><br>Upon admission to the facility, R1's physician orders dated June 20, 2022, indicated wound care was ordered from a home care agency three times a week. Facility staff were to provide wound care to R1's necrotic penis twice a day. R1's progress note dated June 21, 2022, indicated R1 would need assistance with wound care. There was no skin assessment documented in R1's chart. There was no documentation of wound measurements or locations, and it was unclear how many wounds were present upon admission, as this information was not documented.<br><br>R1's MAR dated June 21, 2022, indicated wound care was also to be performed by a home care agency three times weekly. The MAR did not indicate which wound/s the home care agency was/were expected to manage. On June 20, 2022, a staff member initialed on shift 1 and shift 2 that the resident was unavailable. No further information was documented on the June 2022 MAR regarding wound care provided by the home care agency.<br><br>R1's MAR dated July 1, 2022, again indicated wound care was to be performed by a home care agency three times weekly. It was not indicated which wound/s the home care agency was/were | 02310 | | |

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| 02310 | Continued From page 3<br><br>expected to manage. No information was documented on the July 2022 MAR regarding wound care provided by the home care agency.<br><br>An order on R1's July 2022 MAR dated July 5, 2022, indicated that staff were to change R1's bandage every three days and as needed to R1's lower right leg. On July 8, 2022, and July 11, 2022, staff documented that wound care was not provided because R1 was at dialysis. There was no other indication on the MAR that the resident received wound care to his lower leg by facility staff. There was no documentation of measurements or appearance of R1's leg wound.<br><br>A progress note dated July 5, 2022, indicated R1 declined to sign up for hospice care, so the home care agency was contacted to initiate wound care services. Per the progress note, the wound on R1's leg continued to weep and was not expected to heal due to comorbidities. The note included the only measurements and description of R1's leg wound, or any wound, in R1's chart. The progress note included the first mention of scabbing on the fingers of R1's right hand. There were no further measurements or descriptions of R1's wounds prior to or after this note.<br><br>A progress note dated July 6, 2022, indicated the home care agency would visit R1 on July 8, 2022. A progress note dated July 8, 2022, indicated R1 declined wound care from the home care agency. A progress note dated July 11, 2022 (the day R1 was admitted to the hospital), indicated that the home care agency was notified of a wound on R1's bottom on July 8, 2022, and was asked to follow that wound along with R1's other wounds.<br><br>R1's medical record reviewed on January 12, 2023, lacked any further documentation of | 02310 | | |

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| 02310 | Continued From page 4<br><br>follow-up assessment regarding any of R1's wounds, notification to the physician, and specific direction to staff regarding interventions to prevent worsening of the wounds.<br><br>A progress note dated July 11, 2022, indicated R1's family member requested R1 be sent to the hospital. The dialysis clinic had contacted R1's family member, informing him that the resident had feces all over him and was not very clean.<br><br>Home care agency progress notes indicated a home care nurse visited R1 on June 25, 2022 but did not open R1 to services. A home care note dated July 1, 2022, indicated the facility informed the home care agency that R1 had been opened to hospice. There were no other progress notes written by the home care agency after July 1, 2022. However, an agency nurse confirmed that R1 had been referred to the agency a second time, after confirming R1 had not been admitted to hospice, and declined services. The agency nurse confirmed R1 was never opened to services for wound care with the home care agency.<br><br>R1's hospital record dated July 11, 2022, indicated the resident had diagnosis including non-healing ulcer of multiple sites of lower extremity, necrosis of tip of penis, necrosis of finger, end stage renal disease, and diabetes type 2.<br><br>R1's hospital record from July 11, 2022 indicated the principle problem was non-healing ulcer of multiple sites of lower extremity, and active problems of necrosis of the tip of the penis, and necrosis of finger. Upon physical examination, open wounds, ulcers, and scabbed areas to multiple places on R1's bilateral upper extremities | 02310 | | |

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| 02310 | Continued From page 5<br><br>(BUE) and bilateral lower extremities (BLE) were noted. R1's index finger looked necrotic, with dusky or nonviable fingers involving his fourth and fifth fingers of the left hand. R1's lower extremities revealed partial desquamation and open wounds of both great toes. The wounds were described at bleeding and painful. There also appeared to be stool on the bottom of his feet. Dried feces were noted on R1's buttocks, groin, and thighs. It was documented that R1's living condition was suboptimal and deserved better care of his wounds.<br><br>A review of R1's death record indicated the immediate cause of death as non-healing ulcers of multiple sites of lower extremity. The manner of death was indicated as natural.<br><br>During an interview on January 12, 2023, at 1:30 p.m., the director of nursing (DON)-A said did not know if facility nurses provided wound care for R1. DON-A never saw R1's wounds but was aware that R1 had wounds. DON-A said resident wounds are managed by a home care agency, and the agency assumes full responsibility for wound management. The facility did not maintain wound care records.<br><br>The facility policy titled Initial and On-going Assessment of Residents, dated July 1, 2021, a comprehensive assessment would include skin conditions and the service plan would be updated as necessary based on resident needs.<br><br>No further information was provided.<br><br>Time period for correction: Two (2) days. | 02310 | | |

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| 02360 | Continued From page 6 | 02360 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure 1 of 1 residents reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |