Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL374843882M
Compliance #: HL374844357C

Date Concluded: October 9, 2024

Name, Address, and County of Licensee Investigated:

Stonecrest Living
3601 Shady Oak Rd
Minnetonka, MN 55305-4220
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, 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 the resident when staff failed to provide ongoing monitoring and assessment for change in condition of an existing toe wound.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting accounts provided, there was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect. The resident was treated at a local hospital and did not return to the facility.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator also interviewed the resident's primary care provider. The investigation included review of the resident record, hospital records, podiatry records, personnel files, staff schedules, and facility policies and procedures. The investigator toured the facility and observed staff interactions and infection control practices.

The resident resided in an assisted living facility with a diagnosis of diabetes. The resident's service plan included assistance with activities of daily living, medication administration, meals, and housekeeping. The resident's assessment indicated a history of foot pain and was followed by podiatry.

Complaint documents indicated a concern that facility staff used a knife to cut open the resident's foot and the foot became infected.

The resident attended scheduled podiatry appointments. Podiatry notes indicated the resident had a history of non-compliance with wound care and did not follow podiatry recommendations for footwear. The resident acquired an infection which progressed over many weeks and resulted in amputation of the infected toe.

The resident's medical record indicated staff monitored and provided wound care according to physician's orders. The medical record included no documentation of staff removing any area of skin on the resident's foot.

During interview with the resident, he stated after multiple complaints to the manager about a painful area on the toe of his right foot, he was directed to see the nurse. Sometime later that day, the manager called him into his office and used a "scalpel knife" to remove a corn from the bottom of the small toe on his right foot. The resident stated the area became infected and resulted in amputation.

During an interview, the facility administrator/manager denied providing any medical assistance of any type to the resident.

During an interview, a member of facility management indicated the administrator did not provide any direct care to residents and was not aware of any treatment provided to the resident by the administrator. The management staff stated any concerns involving a resident's foot care would be handled by the facility nurse. The management staff stated that following a scheduled podiatry appointment, the resident was sent to the hospital for further evaluation and treatment due to severity of the wound.

During an interview with a facility nurse, she stated two weeks after admission to the facility, a callused wound appeared on the resident's toe. At that time, the resident was not able to recall when the wound first appeared. The nurse urged the resident to seek treatment at that time, but the resident declined. The nurse stated that the resident's care plan was updated as ordered by the podiatrist and wound care was provided as directed. The nurse assessed the wound and did not observe signs of infection. The nurse was not aware of any report of the administrator/manager performing treatments or providing foot or wound care to the resident.

During an interview with the podiatrist, he stated the resident initially presented with an ulcer and after a debridement procedure (removing of tissue with a surgical instrument) an antibiotic

ointment was prescribed to be applied twice a day to the affected area of the foot. At a follow-up appointment one week later, he advised the facility to seek a high level of care for the resident.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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
	37484	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST LIVING	3601 SHADY OAK ROAD MINNETONKA, MN 55305

(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 August 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL374844357C/#HL374843882M. No correction orders are issued.	0 000		