Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378163681M
Compliance #: HL378164102C

Date Concluded: August 19, 2024

Name, Address, and County of Licensee Investigated:
Lindstrom Senior Living
30455 Lehigh Ave
Lindstrom, MN 55045
Chisago County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 facility failed to follow the resident's plan of care and did not change the resident's wound dressing daily.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although the facility staff changed the resident's foot dressing according to the provider order, facility staff failed to notify the nurse of the resident's change in skin condition for an unknown amount of time delaying treatment of the ulcers. The resident developed open ulcers (an open sore or wound that developed on the skin) on the right second and third toes and required a partial right foot amputation.

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigator contacted a family member of the resident and the resident's primary provider. The investigation included review of the resident records, hospital records, facility

incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and diabetes with a history of a right great toe amputation. The resident's service plan included stand by assistance with bathing, dressing, and putting the resident's compression socks on in the morning and taking the compression socks off at night. The resident had severe cognitive impairment, poor decision making, was confused and forgetful.

The resident's progress notes indicated one day, staff noticed "a sore" that was red- and yellow-colored on the resident's right second and third toes. Staff notified the resident's primary care provider, and the resident was evaluated that same day.

The provider notes indicated the resident had two open ulcers on the resident's toes. Staff were to cleanse the ulcers with soap and water, dry thoroughly, apply wound cleanser and cover with a dressing every four days and as needed when soiled.

Three days later; the resident was transported to the hospital for evaluation of the right toe ulcers because of increased right foot and ankle redness, edema, and yellow bloody drainage.

The hospital records indicated the resident's toes were "grossly infected", purulent (pus) wound of the right second and third toes with erythema (redness) to the middle right foot. The resident was diagnosed with cellulitis (a common and potentially serious bacterial skin infection), osteomyelitis (bone infection) and required a partial right foot amputation. The resident was hospitalized for eight days and discharged back to the facility.

During an interview, the facility nurse stated staff were expected to notify a nurse when a resident had changes to their skin and the provider would be notified. The facility nurse stated she was unaware of the resident's wounds to her foot, until the day that the primary care provider was notified. The facility nurse stated prior to the resident being hospitalized, the facility had no formal process to report concerns with the resident's skin.

During an interview, the resident's provider stated the standard for the facility was to complete routine skin checks for all residents. The provider stated earlier detection of the resident's ulcers could have helped and wound care could had been started sooner. The provider stated staff assisted the resident with cares, and with the size of the resident's ulcers, staff should had noticed the ulcers sooner and reported the concerns to the nurse.

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. Due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Once the facility identified the resident’s wound, the primary care provider evaluated the resident. The facility started a process for monitoring resident’s skin and created a skin assessment form. The staff were educated on completing the resident’s skin checks on bath days.

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
Chisago County Attorney
Lindstrom City Attorney
Lindstrom Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37816	A. BUILDING: _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

(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 ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL378163802M/#HL378164254C #HL378163681M/#HL378164102C On July 23, 2024, 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 88 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL378163681M/#HL378164102C, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced	02360		

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02360	Continued From page 1 by: The facility failed to ensure one of two residents reviewed (R2) was free from maltreatment. Findings include: 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		