Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL393726282M
Compliance Project: HL393729382C

Date Concluded: November 25, 2024

Name, Address, and County of Licensee Investigated:
Talamore Memory Care
289 Karen Drive
Woodbury, MN 55129
Washington County

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

Evaluator's Name: Deb Schillinger, 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 it did not implement necessary services and the resident developed gangrene on his right great toe required amputation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While the facility included monthly nail care upon admission, this was not implemented. Eventually a member of the resident's family discovered the resident's toe was black while helping him with his socks. The resident was sent to the hospital where the toe was found to be gangrenous and required amputation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident record, hospital records, facility internal

investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, end stage kidney disease, coronary artery disease, neuropathy, and type 2 diabetes. The resident's service plan included assistance with dressing, and medication administration. The resident's assessment indicated the resident was cognitively impaired and ambulated independently with a walker. The resident received dialysis outside the facility three times a week on Monday, Wednesday, and Friday.

Upon admission the resident's service plan included daily blood sugar checks and monthly nurse-provided nail care. However, a review of the resident's medical record indicated these services were not implemented for approximately 12 weeks.

At approximately the 12th week the facility discovered the service plan called for blood sugar checks four times daily, but due to a clerical error this had not been implemented. The facility then implemented the blood sugar checks as indicated in the service plan.

Later that same week, the resident's progress note indicated a family member changed the resident's socks and found the resident's right great toe was black. The facility staff notified the nurse manager and medical provider. The resident went to the emergency room and admitted to the hospital.

The resident's hospital records indicated the resident's toe was gangrenous. The same documents indicated it was unclear how long the symptoms had been present due to the resident's memory impairment but suspected the issue had been present for weeks or months. Three days later, the resident underwent a right great toe amputation to prevent the spread of gangrene.

The facility internal investigation indicated several staff members reported setting up clothing for resident who then dressed himself on days he received dialysis but refused dressing assistance on the days he did not go to dialysis. The same internal investigation indicated on shower days; the resident refused staff assistance. However, the facility indicated the resident completed his own showers as staff members observed him with wet hair, and the shower was wet.

During an interview, a nurse manager stated the resident refused assistance with dressing on the days he did not need to go to dialysis. The nurse manager stated the caregivers set out clothing and the resident would change his own clothing and socks before they could assist him.

During an interview, an unlicensed staff member stated the resident did not like unlicensed caregivers to do things for him and refused cares many times. The unlicensed caregiver

reported the resident did not want his socks removed and stated he could change his own socks.

During an interview, the family member stated the family visited often and communicated with the facility nurse regarding medications but were not notified of resident not receiving or refusing services listed on the service plan.

During an interview, a nurse stated the service plan developed upon the resident's admission to the facility included monthly nail care provided by the nursing department. However, upon review of the documentation, she stated there was no documentation in the resident's medical record the service had been provided. The nurse stated the monthly cares landed on a Wednesday, but that was also one of the resident's dialysis days and the nail care should have been moved to a different day of the week to accommodate the resident's dialysis schedule.

The resident's service plan indicated the resident would receive a 30-minute visit from a facility nurse on the first Wednesday of the month where nail care would be provided. However, a review of the resident's medical record did not identify documentation these monthly nail care visits took place.

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: The facility internal investigation indicated implementation of a process for a facility nurse to evaluate a resident's feet every two weeks if they have a diagnosis of diabetes.

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
The Woodbury Police Department
The Woodbury City Attorney
The Washington County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39372	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING WOODBURY	289 KAREN DRIVE WOODBURY, MN 55129

(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 November 5, 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 173 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL393729382C/#HL393726282M, 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 by: The facility failed to ensure one of one resident(s) reviewed (R1) 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		