



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL398548929M

Date Concluded: May 3, 2024

Compliance #: HL398546589C

Name, Address, and County of Licensee

Investigated:

Comfort Assisted Living LLC.

721 East 152nd Street

Burnsville, MN 55337

Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN

Special Investigator

Rhylee Gilb, RN

Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected a resident when the AP failed to schedule an appointment with primary care provider after new medical issues developed including a wound. The AP completed wound care and administered medications without a medical provider's order.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for maltreatment. The AP failed to transcribe and provide wound care for the resident's chronic wounds following prescriber orders. The resident went to the emergency room (ER) when the medical provider discovered concerns regarding the AP's wound care. The resident had developed the presence of new wounds. The resident returned to the care of the

AP at her facility and failed to assess the resident upon return from the ER. The resident returned to the hospital two weeks later with the presence a new pressure ulcers to her buttocks.

The investigator conducted interviews with facility staff members, including administrative staff. The investigator contacted the clinic and conducted interviews with nursing staff and medical provider. The investigator also interviewed family. The investigation included review of medical records, hospital and clinic records, personnel files, and facility policies. Also, the investigator toured the facility and observed medication administration process.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, diabetic peripheral neuropathy, peripheral artery disease (impaired circulation), and dementia.

The resident's hospital record indicated prior to the resident's admission to the facility, the resident had a two-month hospital stay for treatment of severe sepsis of cellulitis (skin infection) in her left foot. The resident had surgery to remove her third and fourth toes on left foot. The resident's surgical site transplant site had healed. The resident had chronic dead tissue to her left great toe and second toe. Approximately two weeks prior to discharge, podiatry evaluated the resident due to presence of a right heel ulcer. There were no signs of infection or need for debridement (removal of infected tissue). The wound bed was eschar (black dead tissue, unable to visualize depth) and there was no odor. The hospital ordered heel protector for the resident. The resident had no other wounds upon discharge.

The resident's hospital discharge orders upon admission to the facility included wound care orders for the right heel to clean daily with a betadine (antiseptic) wipe, cover with a dressing and off load her heels from pressure. Left foot wound care orders directed to change the dressing every other day, cleanse the site with wound cleanser, paint the incision with betadine, cover with a dressing and loosely apply ACE (all cotton elastic) bandage. The resident had a follow up appointment with neurology scheduled for approximately three weeks later. The orders addressed to the AP and acknowledged with handwritten check marks next to each medication order and treatment order, including the wound care orders.

The resident's admission assessment completed by the AP, a registered nurse and owner of the facility, indicated on the resident skin assessment three remarks. The remark identified on the body diagram indicated a missing toe on the left foot. The body diagram had markings on both heels with remarks indicating open wounds, crusted, scabbed and healed. The section for current treatments was left blank. The various assessment forms and care plan lacked any reference to wound care or the use of heel protectors.

The resident's service plan, not signed by family, created by the AP included assistance with mechanical transfers, medication management, grooming, toileting, dressing, and blood sugar checks. The service plan lacked services for wound care.

The facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) form, which was signed by the resident's family, indicated the facility provided basic wound care, diabetic foot/nail care, and compression stockings assistance.

The resident's admission progress note, written by the AP, indicated the resident received a shower and a skin check was completed. The AP wrote the resident's left heel wound was open, almost healed, covered with a dressing and she would observe. There was no other progress notes or other records in the resident's medical record indicating completion of the wound care or status of the resident's wounds until the day of her medical provider visit. There was no record the resident attended her neurology follow up appointment as scheduled.

The resident's clinical records indicated she had a virtual doctor's appointment one and a half months after the resident's admission. This was the resident's first medical appointment since moving to facility. The provider note indicated concerns relating to the AP completing wound care with unknown items not prescribed by a provider. The note indicated the AP stated the wound no longer "stinks" and was looking better. The provider wrote she had not been notified of any concerns related to the resident's toe prior to the visit. The provider instructed the AP to send the resident to the ER for evaluation.

The resident's ER record indicated the resident's chronic left toe wound was stable, but noted a presence of calluses on the resident's right foot (not previously identified in her prior hospitalization). The ER provider noted the calluses were without evidence of ulcer and no concern of infection. The resident returned the facility later that night.

The AP failed to assess the resident upon her return to the facility from the ER. The resident's records lacked any observance of the resident's new right foot calluses.

The resident's progress note indicated two weeks later, therapy reported the resident appeared lethargic and sweating. The AP sent the resident to the hospital.

The resident's hospital records indicated the resident presented with continued, stable necrotic left toe wound, however podiatry identified the resident's right heel had worsened with the presence of two ulcers. The right heel ulcers had eschar tissue and treated with debridement of the site with measurements 3 centimeters (cm) x 2 cm x 0.3 cm deep. In addition, the wound care nurse evaluated the resident due to new pressure ulcers to the residents buttock. The resident had three stage 3 (full thickness tissue loss) pressure ulcers to the inner buttock crease and one ulcer on either side of both buttocks likely related to lack of repositioning. The resident also had new wounds to her right great toe and right second toe.

The resident returned the facility a week later and died the next day. The resident's death record cause of death included severe peripheral vascular disease and dementia.

During the onsite investigation, the AP told the investigator the resident had all paper records. The AP provided the investigator the resident's medical record and indicated the entirety of the resident medical record was in the file. The investigator made copies of every document in the file.

The resident's record lacked a treatment administration record (TAR), although a medication administration record (MAR) was created with the transcribed admission orders with the resident's medications. The resident's record lacked any documentation of services provided to the resident.

During an interview, the medical provider said she saw the resident for a pre-operation assessment several months prior to her virtual visit. During the virtual appointment the family member said the resident's foot was draining. The medical provider said her foot should not still be draining. AP reported that she has been using previous thing for wound care that "she had around the house." She looked at her foot through the video. Her foot looked black and necrotic. She recommended the resident go to the ER.

During an interview, the AP said the resident's foot looked the same since she admitted. The AP said all the wound care documentation completed was in the resident's medical record she provided to the investigator. The AP had no response when investigator asked about lack of wound assessments. When asked about the lack of wound care documentation in the resident's medical record, the AP said she thought it was documented somewhere on MAR or TAR. The investigator also informed AP there was no documented notes for the heel protectors. The AP said the heel protectors were not documented anywhere; the resident always wore the heel protectors.

The next day following the interview, the AP emailed the investigator three months of handwritten TARs. The TARs included wound care and heel protector information. The MAR copied from resident's file showed each month was clearly written with different pens, signed on each date with different types of ink, and easily identified that multiple staff documented their initials. Unlike the MAR, the three TARs were all written with the same pen, written on the same surface, and staff initials were all written in the same handwriting. Also, the heel protectors the AP initially said were not documented on a MAR or a TAR, were documented on the TARs. In addition, the staff initials did not match between the MAR and the TAR for each date of administration.

During an interview, family said initially they were trying to get resident into transitional care, but she was denied. The AP at the facility completed all medical care. They were trying to get therapy to come in and help.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

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: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility called sent to resident to the hospital as directed.

Action taken by the Minnesota Department of Health:

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

Dakota County Attorney

Burnsville City Attorney

Burnsville Law Enforcement

Minnesota Board of Executives for Long Term Services and Supports

Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39854	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2024
NAME OF PROVIDER OR SUPPLIER COMFORT ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 721 EAST 152ND STREET BURNSVILLE, MN 55306		
(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL398548929M / HL398546589C</p> <p>On April 16, 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 was one (1) resident receiving services under the provider's provisional Assisted Living license.</p> <p>The following correction order are issued for HL398548929M / HL398546589C, tag identification 330, 1960 and 2360.</p>	0 000	<p>Minnesota Department of Health is documenting the State 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 330 SS=I	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	<p>Continued From page 1</p> <p>accurate and truthful information to the department during a survey, investigation, or other licensing activities.</p> <p>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH). The licensee provided a falsified treatment record after confirming all records were available and received by the MDH investigator while onsite. This deficient practice had the potential to affect all residents and staff.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's application for provisional assisted living licensure indicated owner (O)-A attested she would provide truthful information to MDH.</p> <p>During the entrance conference on April 16, 2024, at 10:10 a.m., O-A stated all documentation was</p>	0 330		

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0 330	<p>Continued From page 2</p> <p>completed on paper. No electronic records were kept.</p> <p>During the onsite visit on April 16, 2024, at 11:30 a.m., MDH investigator reviewed resident (R)-1's medical record. R1's entire medical record was scanned into the investigation file.</p> <p>R1's medical record was reviewed. R1's admitted on August 27, 2023.</p> <p>R1's hospital discharge orders in the licensee's medical record, dated August 27, 2023, included medication orders with highlighting and hand written check marks. Treatment orders included compression stockings with a hand written note "unavailable d/c [discontinue] August 27, 2023." Wound care orders and instructions for the left groin had a handwritten note "healed." Wound care orders for the right heel indicated daily swab with a betadine wipe, cover with dressing, and off load heels at all times. Consider Rooke Boots (heel protectors). Wound care orders for the left foot indicated to change the dressing every other day, cleanse site with wound cleanser, paint incision with betadine, cover with dressing and loosely apply ACE (all cotton elastic) bandage. Further within the orders for the durable medical equipment order, wound descriptions indicated a chronic left foot ulcer status post excisional debridement down to and including muscle tendon and left 3rd and 4th toe resections. chronic left great toe and 2nd toe ischemia (dead tissue), severe peripheral artery disease (PAD) status post amputation to left 3rd and 4th toe with skin graft covering the area. R1's orders included a neurology follow up appointment scheduled September 20, 2023.</p> <p>R1's admission resident evaluation dated August</p>	0 330		

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0 330	<p>Continued From page 3</p> <p>27, 2023, completed by O-A, under the skin area with human body diagram had bi-lateral heels marked and a mark on the left foot toe. In the description was written:</p> <ol style="list-style-type: none"> 1. crusted open wound, dried [sic], healed (1 was not identified which area on the foot diagram). 2. illegible writing of either the words "crusted" or "dressed" missing toe (2 was identified on the diagram on the left foot toe). 3. scab open area, healed (3 was not identified which area on the foot diagram). <p>The section for current treatments was left blank. The assessment lacked any reference to wound care.</p> <p>R1's service plan dated August 27, 2023, failed to include wound care. The treatments section included blood sugar checks four times per day.</p> <p>R1's medication administration record (MAR) failed to include any treatment orders for wound care or heel protectors.</p> <p>R1's record lacked treatment administration records (TAR) or service delivery records.</p> <p>During an interview on April 19, 2024, at 3:05 p.m., O-A said R1's entire record was in the medical record O-A gave MDH investigator while onsite. MDH investigator discussed lack of wound care documentation in R1's medical record including lack of dressing change documentation. O-A said she thought it was documented somewhere on the MAR or the TAR. MDH investigator also informed O-A there was no documentation notes for the heel protectors. O-A said the heel protectors were not documented anywhere to let the staff know to apply or remove them. O-A said R1 always wore the heel protectors. MDH investigator told O-A a copy of</p>	0 330		

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0 330	<p>Continued From page 4</p> <p>the MAR was obtained but no TAR was found in the medical record and the MAR lacked documentation of R1's wound care.</p> <p>On April 22, 2024, at 1:14 a.m., O-A emailed R1's TAR for August 2023, September 2023, and October 2023 to MDH investigator.</p> <p>During record review, the MAR copied from R1's file during the onsite visit showed each month was clearly written with different pens, signed on each date with several different types of ink, and easily identified that different staff documented their initials. Unlike the MAR, the three TARs emailed by O-A were all written with the same pen, written on the same surface, and staff initials were all written in the same handwriting. Also, the heel protectors O-A initially said were not documented on a MAR or a TAR, were documented on the TARs emailed by O-A. In addition, the staff initials did not match between the MAR and TAR for each date.</p> <p>O-A was unable to locate a staff schedule for September 2023 and October 2023.</p> <p>TIME PERIOD TO CORRECT: Two (2) days.</p>	0 330		
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments	01960		
	Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must			

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01960	<p>Continued From page 5</p> <p>document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to transcribe and provide wound care orders for one of one residents (R1) reviewed. R1's physician directed the licensee to transport R1 to the emergency room (ER) for evaluation of a toe infection.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>During the entrance conference on April 16, 2024, at 10:10 a.m., O-A stated all documentation was completed on paper. No electronic records were kept.</p> <p>During the onsite visit on April 16, 2024, at 11:30 a.m., MDH investigator reviewed resident (R)-1's medical record. R1's entire medical record was scanned into the investigation file.</p> <p>R1's hospital records from admission June 17, 2023, through August 27, 2023, indicated R1 was treated for severe sepsis of cellulitis (skin infection) in her left foot. R1's 3rd and 4th toe were amputated, required debridement of the</p>	01960		

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01960	<p>Continued From page 6</p> <p>surgical site, received a skin graft. R1 had chronic left great toe and 2nd toe ischemia (dead tissue). R1's skin graft site of her left groin was healed on July 21, 2023. On August 10, 2023, podiatry evaluated R1's right heel ulcer. There was no signs of infection and no need for debridement. Heel protectors were ordered. On August 22, 2023, the last wound care note with photograph of R1's right heel indicated The wound bed was eschar (black dead tissue, unable to visualize depth) and there was no odor. There was no other wound injuries noted in R1's hospital record. There were no changes to R1's wound care treatment orders through discharge to the licensee on August 27, 2023.</p> <p>R1's medical record was reviewed. R1's admitted on August 27, 2023. R1's diagnoses included dementia, diabetes, and peripheral vascular disease.</p> <p>R1's hospital discharge orders in the licensee's medical record, dated August 27, 2023, included medication orders with highlighting and hand written check marks. Treatment orders included compression stockings with a hand written note "unavailable d/c [discontinue] August 27, 2023." Wound care orders and instructions for the left groin had a handwritten note "healed." Wound care orders for the right heel indicated daily swab with a betadine wipe, cover with dressing, and off load heels at all times. Consider Rooke Boots (heel protectors). Wound care orders for the left foot indicated to change the dressing every other day, cleanse site with wound cleanser, paint incision with betadine, cover with dressing and loosely apply ACE (all cotton elastic) bandage. Further within the orders for the durable medical equipment order, wound descriptions indicated a chronic left foot ulcer status post excisional</p>	01960		

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01960	<p>Continued From page 7</p> <p>debridement down to and including muscle tendon and left 3rd and 4th toe resections. chronic left great toe and 2nd toe ischemia (dead tissue), severe peripheral artery disease (PAD) status post amputation to left 3rd and 4th toe with skin graft covering the area. R1's orders included a neurology follow up appointment scheduled September 20, 2023.</p> <p>R1's admission resident evaluation dated August 27, 2023, completed by O-A, under the skin area with human body diagram had bi-lateral heels marked and a mark on the left foot toe. In the description was written:</p> <ol style="list-style-type: none"> 1. crusted open wound, dried [sic], healed (1 was not identified which area on the foot diagram). 2. illegible writing of either the words "crusted" or "dressed" missing toe (2 was identified on the diagram on the left foot toe). 3. scab open area, healed (3 was not identified which area on the foot diagram). <p>The section for current treatments was left blank. The assessment lacked any reference to wound care.</p> <p>R1's service plan dated August 27, 2023, failed to include wound care. The treatments section included blood sugar checks four times per day.</p> <p>The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) form dated August 27, 2023, signed by R1's family, indicated the licensee provided basic wound care, diabetic foot/nail care, and compression stockings assistance.</p> <p>R1's medication administration record (MAR) failed to include any treatment orders for wound care or heel protectors.</p>	01960		

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(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
01960	<p>Continued From page 8</p> <p>R1's progress note August 27, 2023, indicated R1 admitted to the licensee, received a shower and skin check was completed. R1's left heel wound was open, almost healed, covered with a dressing and O-A would observe. There was no other entries in R1's progress notes regarding completed wound care or wound care status.</p> <p>R1's progress note dated October 10, 2023, indicated R1 was transferred to the hospital for possible toe infection.</p> <p>R1's clinic records dated October 10, 2023, indicated the visit was a video visit. R1's medical provider (MP)-C wrote concerns regarding O-A completing wound care on R1's left great toe using unknown items not prescribed by a provider. O-A reported the toe does not stink anymore and was looking better. MP-C noted she had not been notified of any concerns with R1's toe prior to the visit. MP-C instructed to send R1 to the emergency room (ER) for evaluation.</p> <p>R1's ER record dated October 10, 2023, indicated presence of calluses noted on R1's right foot without evidence of ulcer or concern for infection. R1 had necrosis of her left great toe with no drainage. No X-rays were completed at the ER. R1 was discharged to the licensee.</p> <p>R1's progress note had small print writing in between notes written on October 10, 2023 and October 13, 2023, indicated R1 returned at 1:30 a.m.</p> <p>R1's record lacked assessment of R1 upon return from the ER and assessment of R1's newly identified right foot calluses.</p> <p>R1's progress note dated October 24, 2023,</p>	01960		

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01960	<p>Continued From page 9</p> <p>indicated therapy reported R1 was sweating and appeared lethargic. R1 was sent to the hospital.</p> <p>R1's hospital record dated October 24, 2023, through October 31, 2023, indicated R1 presented to the hospital with a hard crusted necrotic left great toe and dried dark scabbing right heel. On October 25, 2023, podiatry evaluated R1's wounds. Podiatry noted left great toe with gangrene similar to previous. R1's right heel had worsened since last seen. R1's right heel had two eschar (dead tissue) ulcers and treated with debridement of the site with measurements 3 centimeters (cm) x 2 cm x 0.3 cm (deep). Also on October 25, 2023, the wound care nurse evaluated new pressure ulcers to R1's buttock and foot. R1 had three stage 3 (full thickness tissue loss) pressure ulcers to her inner buttock crease and one ulcer on each side of her buttock. R1 had new wounds on her right foot great toe and 2nd toe from previous hospitalization. Palliative care was consulted and R1 returned to the licensee on October 31, 2023.</p> <p>R1's record lacked treatment administration records (TAR) or service delivery records.</p> <p>R1's death record indicated R1 died on November 1, 2023, with cause of death due to severe peripheral vascular disease and dementia.</p> <p>During an interview on April 19, 2024, at 3:05 p.m., O-A said R1's entire record was in the medical record O-A gave MDH investigator while onsite. MDH investigator discussed lack of wound care documentation in R1's medical record including lack of dressing change documentation. O-A said she thought it was documented somewhere on the MAR or the TAR. MDH investigator also informed O-A there was no</p>	01960		

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01960	<p>Continued From page 10</p> <p>documentation notes for the heel protectors. O-A said the heel protectors were not documented anywhere to let the staff know to apply or remove them. O-A said R1 always wore the heel protectors. MDH investigator told O-A a copy of the MAR was obtained but no TAR was found in the medical record and the MAR lacked documentation of R1's wound care.</p> <p>TIME PERIOD OF CORRECTION: Two (2) Days.</p>	01960		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>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.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		