Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL217152322M
Compliance #: HL217151441C

Date Concluded: July 29, 2024

Name, Address, and County of Licensee Investigated:
Covenant Living of Golden Valley
5800 St. Croix Avenue North
Golden Valley MN 55422
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

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 they failed to assess the resident after changes in condition (injury to left leg, edema in both legs, and increased falls), and failed to implement new fall prevention interventions which led to a fall with injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a history of falls and lower leg edema, which led to skin breakdown. The facility assessed the resident after each incident and implemented new interventions. Although the resident received cuts on his forehead and hand, there was no evidence lack of interventions contributed to the fall.

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

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

The resident lived in an assisted living facility. The resident's diagnoses included dementia, heart disease and chronic kidney disease. The resident's service plan included assistance with bathing, dressing, grooming, toileting, and reminders to use his walker. The resident's assessment indicated the resident had a history of falls and edema of both lower legs.

The resident's medical record indicated the resident initially moved into the independent living section of the facility and then to the memory care unit as his memory care service needs increased. The record indicated the resident experienced occasional falls and had a period of a cluster of falls one week, with one resulting in a cut to his head and finger. The record indicated around the same time the resident had increased swelling of the lower legs and a chronic infection on his leg (cellulitis). The medical provider assessed the resident and sent him to the hospital.

The resident's hospital record indicated the swelling was a progressive condition (lymphedema) caused by the inability of the lymphatic system to transport fluids that normally leak from the blood, which led to cellulitis. Lab work showed the resident was positive for COVID-19. The resident discharged on a Friday with orders for antibiotics, elevation of legs, as well as home health skilled nursing for wound care and compression stockings or wraps to lower legs.

The resident's record indicated an outside home health nurse came to the facility the following Monday for an assessment with a plan to return two to three times per week. The resident's medical provider prescribed several different antibiotics for the cellulitis and diuretics (medication used to help the kidneys remove fluid buildup).

During an interview a nurse stated the resident had edema when admitted to the facility and the medical provider tried various diuretics. The nurse stated the resident had a hard time with elevating his legs and wearing the compression socks, but when he did, the edema improved. The nurse stated nursing followed-up on all fall incidents and included additional interventions for staff, such as more frequent safety checks. The nurse stated the facility team along with the resident's family agreed the resident required long term care and was transferred.

During investigative interviews, multiple staff members stated the resident lived at the facility for several years and when he refused a service staff would reapproach later, often several times. Staff stated the resident's health declined until he required more care than the facility could provide.

During an interview, the resident's medical provider stated the resident's edema was present for several years, determined to be lymphedema, which responded to elevation and compression. The medical provider stated the wound on the resident's leg was related to the edema, which caused fluid to weep out, and placed the resident at risk for skin breakdown. The

medical provider stated the resident's cluster of falls was likely related to his diagnosis of COVID-19.

During interviews family members stated the resident had several unwitnessed falls and although could not predict if it would have prevented falls, expressed concern of the staffing levels at the facility. The family members stated the facility provided appropriate services for the resident when first admitted to the memory care unit, but acknowledged the resident's disease progression required a higher level of care. The family members stated the resident began receiving hospice services, moved to the facility's long term care center on the same campus at the insistence of the family, and was doing well.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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:
The facility sent the resident to the hospital and to the rehabilitation unit upon his return due to a need for skilled nursing. The facility admitted the resident to their care center approximately a week later due to increased needs related to progression of dementia.

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
	21715	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSISTED LIVING	5800 ST CROIX AVENUE NORTH CRYSTAL, MN 55422

(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 July 18, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL217151441C/#HL217152322M. No correction orders are issued.	0 000		