Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302275721M
Compliance #: HL302277964C

Date Concluded: December 18, 2024

Name, Address, and County of Licensee Investigated:
Emeralds of Grand Rapids
2815 Highway 169 S
Grand Rapids, MN 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt 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 the resident when facility licensed staff failed to assess, monitor, and provide the resident's on-going wound care according to the provider orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility's licensed practical nurse collaborated with the registered nurse from a contracted home health agency and the resident received assessments and wound care as the resident allowed. Although unlicensed facility staff were trained by a licensed practical nurse and not a facility registered nurse on the resident's wound care and the contracted home care nurse provided assessments and on-going monitoring of the resident's wound instead of the facility registered nurse, that failure did not meet the definition of neglect but resulted in licensing orders.

The investigator conducted interviews with facility staff members, including administrative staff, licensed nursing staff, and unlicensed staff. The investigator contacted a home care agency and

physician rounding service. The investigation included review of the resident records, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, home care notes, rounding provider notes and orders, and related facility policy and procedures. Also, the investigator observed unlicensed facility staff provide wound care.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes mellitus, chronic osteomyelitis (infection of the bone), chronic methicillin-resistant Staphylococcus aureus (antibiotic resistant organism) and a right above the knee amputation. The resident's service plan included assistance with morning cares, transfers, toileting, and laundry. The resident was alert and oriented, utilized a slide transfer board and an electric wheelchair, was active with community groups, and was independent with driving.

The resident's record indicated the resident had a right leg above the knee amputation the previous year. The following spring, the resident developed multiple wounds to the left foot and shin due to his diagnoses and a recent trauma injury. The provider ordered home health wound care services and the contracted home care staff provided wound care as ordered from two to five times a week. The resident record indicated the resident was at times non-compliant with wound care instructions and would refuse wound care assistance. Mid-summer, the resident required an evaluation at a hospital for an infection in the left foot and required hospitalization. When discharged from the hospital, the provider recommended a left above the knee amputation. The resident chose to delay the amputation until the procedure could be discussed with family.

Hospital records indicated the resident was seen in the summer at the emergency room twice for worsening ulceration of wounds. The medical provider noted the resident had the wounds for several months. At one point the resident was hospitalized overnight and discharged with a wound care referral and recommendation for a left leg above the knee amputation. A few days after the hospitalization the resident had a surgical consult, and the surgeon supported the recommendation for an above the knee amputation of the left leg. The wounds were not healing, and late summer, the left foot wound required debridement twice after observation of maggots present in the wound. The resident's surgical amputation for an above the knee amputation of the left leg was completed the first week of September.

Home Care records indicated the agency provided supplemental wound care services for the resident. Home health records indicated the resident was sent to the emergency room on two occasions when licensed home care staff suspected infection in the wound and a second incident when licensed home care staff observed wound deterioration and found maggots colonized in the resident's wound. Home care records indicated the resident was educated and instructed at each visit how to assist with caring for the wounds. Home health records indicated the resident was scheduled for a left leg amputation in October 2024, however, the amputation was moved up to the first week of September 2024.

The resident's progress notes indicated a home care agency was providing supplemental wound care. Progress notes indicated a licensed facility staff member collaborated with a home care agency and a rounding medical provider. Early July 2024, a licensed home care staff assessed the resident's wound, expressed concerns with wound deterioration and sent the resident to the emergency room. Late summer of 2024, home care staff informed licensed facility staff to observe colonized maggots found in the resident's wound and the resident was sent to the emergency room for treatment. The resident's wound was debrided (dead, damaged or infected tissue removed) treated for maggots and the resident returned to the facility. Seven days later, maggots developed in the wound for a second time and the resident drove himself back to the emergency room. The resident had an above the knee amputation of the left leg the first week of September.

During an interview, unlicensed staff stated the resident could be non-compliant with cares and unlicensed staff would encourage and reapproach to achieve the resident's compliance with wound cares. Unlicensed staff stated it was not uncommon for the resident to allow staff to provide wound care in the morning, however, would refuse the evening wound care. Unlicensed staff stated wounds would rapidly deteriorate and unlicensed staff notified the facility's licensed practical nurse. Unlicensed staff stated a weekly rounding provider would update staff on the resident's wounds. Unlicensed staff could not recall a facility registered nurse involved with the resident's wounds and were trained on the resident's wound care by the facility's licensed practical nurse.

During an interview, contracted licensed home care staff stated the resident had started receiving wound care services in the spring after a traumatic injury to his left foot. Contracted licensed home care staff stated home care was at the facility two to three times a week, dependent on the status of the wounds, until the resident had an above the knee left leg amputation. Contracted licensed home care staff stated on one visit the wound was sprayed with a cleanser and noted the wound bubbled with maggot movement. Contracted home care staff contacted a licensed facility staff for observation and sent the resident to the hospital for treatment. Contracted licensed home health staff stated wound observations were completed with a licensed facility staff member present or the facility licensed staff member was updated after every visit. Contracted licensed home care staff stated she provided wound care education and instruction to the resident each visit.

During an interview, licensed facility staff stated the facility shared licensed registered nursing time with a skilled facility located on the same campus. Facility licensed staff stated the resident had multiple wounds the contracted licensed home care staff were managing several days a week and facility staff would fill in on the days home care was not scheduled. Facility licensed staff stated home care staff noted maggots in the wound and that the wound had deteriorated rapidly over a weekend. Facility licensed staff stated she was unaware a facility registered nurse was required to be involved with the wounds since she was collaborating with a rounding provider and a contracted home health agency.

During an interview, the resident stated his right leg had been amputated the year prior. The resident stated he injured his left foot early in the spring and he developed foot wounds that would not heal. The resident stated he had wound care support from a home health care agency and facility staff provided wound care on days home care was not scheduled. The resident stated when maggots were found in the wound, licensed home care staff sent him to the hospital for treatment.

During an interview, the family stated the resident previously had several infections from knee surgeries and other health issues that prevented wounds from healing.

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 worked collaboratively with an outside agency to provide the resident with wound care.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	C 11/07/2024

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THE EMERALDS AT GRAND RAPIDS ASSISTED LIVING	2815 HIGHWAY 169 SOUTH GRAND RAPIDS, MN 55744

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL302275721M/#HL302277964C On November 7, 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 43 residents receiving services under the assisted living with dementia license. The following correction orders are issued for #HL302275721M/#HL302277964C, tag identification 1620, 1650 and 1950.	0 000	Assisted Living Provider 144G. 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	

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01620	Continued From page 1	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident assessments for one of one resident (R1) with a change in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 2 cause 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). The findings include: Review of medical record indicated R1's diagnoses included diabetes mellitus and osteomyelitis. R1's Service Plan dated May 22, 2024, indicated R1's services included assistance with dressing, transfers and toileting as needed (PRN), housekeeping, and laundry. R1's physician orders dated May 21, 2024 included the following wound care orders: - top part of left foot change every other day. Cleanse with anti-aseptic wound cleanser, apply mupirocin to wound edges and wound bed, pack with alginate, cover with foam dressing. - left shin, change every 3 days and as needed. Cleanse with anti-septic wound cleanser, apply mupirocin to wound edges and wound bed, dress with vaseline gauze, cover with foam border dressing. - Left 2nd toe, change every 3 days and as needed. Cleanse with anti-septic wound cleanser, apply mupirocin to wound bed and edges, dress with vaseline gauze, cover with dry gauze, secure with tape. R1's physician orders dated July 12, 2024 included the following wound care orders: - left lower leg, ulcers and skin tears, cleanse with anasept, pat dry then apply Allevyn gentle border light dressings and change every other day. Contact nurse immediately if wound has	01620		

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01620	Continued From page 3 drainage, odor or redness. - left foot ulcer, keep clean and dry. Cleanse with Anasept gently then at dry. Recommend painting with Betadine twice daily and leave open to air. Cover only if draining. R1's post hospital reassessment dated July 10, 2024, completed and signed by licensed practical nurse (LPN)-C indicated a four centimeter (cm) x three cm with one cm macerated dark area with drainage located on R1's left foot was reported to the LPN by a home care assistant and R1 was asked to go to the emergency room (ER). R1 was hospitalized overnight for intravenous (IV) antibiotics (used to treat infection). The assessment contained an instruction in bold "Report any changes or concerns to the home care RN". R1's Progress Notes dated July 9, 2024, through August 29, 2024, written by LPN-C indicated: - July 9, 2024, 9:21 a.m., resident has an area of 4 centimeters (cm) x 3 cm dark open area with 1 cm maceration around, home care nurse said there was drainage noted. Nurse Practitioner (NP) updated will send resident to emergency room (ER) for eval. - July 9, 2024, 8:31 p.m., resident admitted to the hospital as he has infection in his foot. Admitted for IV antibiotics. - July 10, 2024, resident returned from hospital, started on Zosyn and Vancomycin (antibiotics) during hospital stay. Surgery is recommending above knee amputation (AKA). no other changes to home regimen beyond adding antibiotic. NP updated resident returned, will follow up what at facility July 11, 2024 as resident has no wound care orders. - July 12, 2024, [MD name] seen resident in the hospital and did contact this writer to gibe	01620		

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01620	Continued From page 4 dressing orders. NP and Homecare nurse updated and here today, did dressing orders. Recommend painting with Betadine twice daily. Venous ulcers and skin tear to left lower left to be cleansed with Anasept, pat dry then apply Allevyn gentle border light dressings and change every other day. - July 15, 2024, Resident to clinic to see surgeon, They reviewed wound on left foot. Orders to keep feet clean and dry, cover open wounds, continue antibiotics, continue home care. Follow up in surgery clinic to schedule left leg amputation. - August 27, 2024, 10:17 a.m., cleaned resident foot wound yesterday. Resident had more maceration under foot. Foul odor from foot. Home care alerted writer small worms in wound. Not noted yesterday. Home care does come two times a week to check on wound and do dressing changes. Resident sent to emergency room. - August 27, 2024, 3:11 p.m., resident returned from emergency room. Note from ER - lower left extremity chronic weeping erosive wounds from knee down. Large eschar over great toe from middle toe, fresh bleeding, colony of live maggots eating tissue and pus that is emanating from wound. Chronic ischemic and neuropathic changes to entire limb. Discharge with home care, plan amputation next week. -August 29, 2024, surgery scheduled for 9.4.24. Take half long acting insulin. Stop Variance Sunday, September 1. R1's change of condition assessment electronically signed August 29, 2024, (two days after R1 was seen at the emergency room for maggots in foot wound) indicated R1 was independent with transfers, occasionally needed assistance with toileting, had left lower leg and foot ulcers managed by home health. The assessment lacked wound descriptions,	01620		

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01620	Continued From page 5 measurements and accuracy of R1's health status completed by a registered nurse. A progress note written by LPN-C on September 2, 2024, indicated staff were notified the resident had maggots in the wound. Area black and odorous, dressing changed daily. Nurse Practitioner updated. Resident to emergency room for evaluation. On November 7, 2024, at 12:37 p.m., the investigator observed unlicensed personnel (ULP)-E assist R1 with a sliding board transfer (a technique used to move a person between surfaces when they are unable to use their legs with a rigid flat board between surfaces) from wheelchair to bed, toileting, peri-care and wound care of the buttocks. R1's record lacked change in condition assessments completed by an RN. On November 13, 2024, at 10:00 a.m., LPN-C stated the facility RN had ended employment earlier in the summer and the facility shared a RN with a skilled facility located on the same campus. LPN-C stated a rounding medical provider was kept updated, however, LPN-C was unaware a facility RN was required to be involved with R1's wound care or changes in condition. The licensee's Assessment - Schedules policy dated December 2019, indicated registered nurses would conduct assessments, monitoring, and reassessments face-to-face with residents changes in condition as indicated. The policy indicated nurses shall conduct assessments, monitoring and reassessments consistent with Assisted Living Regulation and the individualized needs of each assisted living resident.	01620		

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01620	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 7 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of one residents (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: Review of R1's medical record indicated R1's diagnoses included diabetes mellitus and osteomyelitis. R1's Service Plan dated May 22, 2024, indicated R1's services included assistance with dressing, transfers and toileting as needed (PRN), housekeeping, and laundry. R1's Service Plans dated May 22, 2024, and October 25, 2024, respectively, lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the residents; and - the schedule and methods of monitoring staff providing services.	01650		

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01650	Continued From page 8 On November 7, 2024, at 12:37 p.m., the investigator observed unlicensed personnel (ULP)-E provide R1 wound care of the buttocks. On November 14, 2024, at 11:26 a.m., clinical nurse supervisor (CNS)-B confirmed through an email R1 received wound care, however, the signed service plans had not been revised and did not include wound care services. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must include a description of the services to be provided, and the frequency of each service, identification of type of staff to provide service, schedule and methods of monitoring staff, and the service plan must be revised, if needed, based on the resident's current assessment or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

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01950	Continued From page 9 professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) trained and verified competency with treatments and therapies for one of one unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: ULP-E was hired on November 19, 2021, to provide direct cares to licensee's residents. On November 7, 2024, at 12:37 p.m., the investigator observed ULP-E assist R1 with peri-care and wound care of the buttocks. Three dime size open sores were observed on R1's right buttock crease. ULP-E applied gloves, provided peri-care and applied an over the counter (OTC) ointment purchased by R1, to the open sores. ULP-E stated R1 had the sores for "two weeks at least I'd say". ULP-E stated	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30227	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 10 unlicensed personnel notified the nurse when a wound was observed. ULP-E clarified the nurse ULP-E was referring to was licensed practical nurse (LPN)-C. On November 7, 2024, at 12:50 p.m., ULP-E stated she had provided cares for R1 throughout R1's left foot infections and left leg amputation process. ULP-E stated unlicensed staff assigned to R1's team completed wound cares on the days home care did not. ULP-E's employee record lacked documentation ULP-E was trained and demonstrated competency to a RN to perform R1's specific wound cares. On November 7, 2024, at 1:40 p.m., LPN-C stated there were no instructions for unlicensed personnel for R1's buttock wounds and unlicensed staff were not trained or competency tested by a RN specifically for R1's prior or current wounds. The licensee's Training and Competency Evaluations For Unlicensed Personnel policy dated November 2019, indicated the registered nurse would assure the unlicensed personnel were trained in the proper method to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure and perform the task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01950		