Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30745017M
Compliance #: HL30745018C

Date Concluded: December 22, 2022

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway, Lino Lakes, MN
55014
Anoka County

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

Evaluator's Name: James Larson RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
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 staff failed to provide wound care resulting in a hospital stay.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. At the time of the onsite visit, there had a been a change in ownership of the facility and limited documentation was available for review. There was no documentation of measurement, description or status of the wound and it is unknown the extent of assessment, monitoring and/or treatment that was provided by the facility. However, available documentation indicated nursing staff was aware of the wound. There is evidence staff implemented care plan interventions, monitored the area, and when signs and symptoms of infection were observed, the resident was sent to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident's family. The investigator conducted an onsite visit, which included review of resident medical records, facility policies and procedures, and personnel records.

The resident resided in an assisted living with Dementia care facility. The resident's diagnoses included type 1 diabetes mellitus, epilepsy, non-traumatic chronic subdural hemorrhage, chronic embolism, and thrombosis of right femoral vein, morbid (severe) obesity, and edema.

The resident's service plan included assistance with medication management and activities of daily living. The service plan also indicated the resident required the assistance of two staff and a mechanical lift for transfers. The resident's assessment indicated the resident was wheelchair bound and had a history of incontinence. The care plan identified the resident required assistance with incontinent care and repositioning every two hours.

During the onsite investigation, a current staff member who had previously worked at the facility during the time of the resident's stay, was interviewed. The staff member recalled the resident had a pressure ulcer on his coccyx and nursing staff provided treatment to the area. The staff member also thought the resident received outside agency wound care services for treatment of the wound.

The resident record indicated a pressure ulcer developed on the resident's coccyx during his stay at the facility. There was no description or detail of the size or status of the ulcer in the record. There was no documentation available to support wound care services were provided by an outside agency. Available documentation indicated nursing staff was aware of the ulcer, monitored and provided treatment to the area. The resident's care plan identified updated interventions of off-loading to one side to reduce pressure to the coccyx area and repositioning every two hours. Documentation further indicated staff observed signs and symptoms of infection and the resident was transferred to the hospital for evaluation and treatment.

During an interview with the resident's family, they indicated the resident's skin was intact upon his admission to the facility. The family was aware of the pressure ulcer and that it was being closely monitored and treated and were told by the facility that the area was healing. Two days later, the resident was sent to the hospital and the wound had worsened. The family was concerned due to the different information they were provided and expressed additional concerns regarding the provision of care and availability of staff during the resident's stay at the facility.

The current administration was interviewed and aware of concerns with previous management. They indicated new leadership, policies, and procedures had been implemented upon their acquisition of the facility.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
Once discharged from the local hospital, the resident did not return to the facility. The ownership of the facility has since changed and no record of additional actions taken at the time of the incident were available.

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
	30745	A. BUILDING: _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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 Initial comments On November 16, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL30745016C/#HL30745015M and #HL30745018C/#HL30745017M. No correction orders are issued.	0 000	STATE HOME CARE PROVIDER/ASSISTED LIVING PROVIDER POC TEXT Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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	

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0 000	Continued From page 1	0 000	SUBDIVISION 1-3. No plan of correction is required for tag 2360. Please refer to the public maltreatment report for details.	