Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL332542281M
Compliance #: HL332543897C

Date Concluded: October 28, 2022

Name, Address, and County of Licensee Investigated:
Golden Horizons of Sandstone
1109 Lundorff Drive
Sandstone, MN 55072
Pine County

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

Evaluator's Name: Carol Moroney 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 alleged perpetrator (AP) neglected the resident when the resident's toes were not assessed timely.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Staff interviews and facility records conflict with one another of how the resident's toes assessment was missed. It was unable to be determined when the resident developed the wound between her 4th and 5th toes.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the local hospice agency licensed staff. The investigation included review of the resident's medical record, the facility's internal investigation, the AP's personnel file, relevant policy, and procedures, and the resident's hospice records. The resident was not able to be observed.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's disease, dementia, and urinary retention. The resident's service plan included assistance needed with dressing, grooming, bathing, and compression hose. The resident's assessment completed prior to the allegation indicated no wounds or skin problems were present.

The resident's facility progress notes identified the AP completed a skin assessment of the resident's right arm. The AP took the resident's vital signs and contacted the provider to report it. The AP transcribed the prescribed treatment for cellulitis.

Eight days later, the facility nursing progress notes included a wound care note completed by the hospice nurse regarding a sore between the resident's 4th and 5th toes. Interviews with the hospice nurse indicated unlicensed staff reported to the hospice nurse, the sore was present for five days. The facility's investigation revealed the AP did not complete an assessment timely on the resident's toes. No documentation was provided of when the unlicensed staff reported the wound to the registered nurse.

The facility records reviewed lacked an assessment on the resident's toes, completed by the facility's registered nurse.

During multiple facility leadership staff interviews, the information received was conflicting regarding the wound assessment, and the AP's involvement in the lack of assessment. In addition, during multiple facility nursing staff interviews, information reported was conflicting amongst interviews.

The facility policies indicated the nurse shall conduct an in-person assessment, monitoring, and reassessment with any change of condition. Another facility policy indicated the staff are trained to notify the nurse when skin issues was observed.

The AP declined an interview.

The resident had expired. The death record listed the cause of death as Alzheimer's.

The family stated the facility gave the resident good care and were not aware of any problems.

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.

Vulnerable Adult interviewed: No, the resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, declined.

Action taken by facility:
The facility reported they have pursued a different direction and hired another nurse.

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
	33254	A. BUILDING: _____ B. WING _____	C 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE GOLDEN HORIZONS	1109 LUNDORFF DRIVE SANDSTONE, MN 55072

(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 October 3, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL332542281M/HL332543897C. No correction orders are issued.	0 000		