Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200748222M
Compliance #: HL200744621C

Date Concluded: January 23, 2025

Name, Address, and County of Licensee Investigated:
Centennial Villa
500 Park Street E
Annandale, MN 55302
Wright 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 staff failed to provide the resident with transfer and toileting assistance according to the resident's care planned needs. As a result, the resident fell with injuries. Facility staff failed to recognize and provide wound care for the resident with a change in condition following the fall. In addition, staff failed to provide the resident with escorts and a wheelchair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the resident's fall, the resident was independent with transfers and toileting. The resident developed an infection on her shin (front calf below the knee) as the result of an abrasion sustained from the fall, however, the infection developed five weeks after the initial injury. Staff recognized the change in the resident's wound, contacted family, and the provider for orders. The facility did not manage the resident's medications, did not have oversight of the resident's antibiotics, and could not verify the resident was taking the antibiotics as ordered. The facility

completed face-to-face medication assessment's, reassessments of the wounds, added services, and communicated with the family about the concern with the resident's self-administration of antibiotics.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record(s), hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed unlicensed facility staff provide cares.

The resident resided in an assisted living facility. The resident's diagnoses included anemia (low hemoglobin), hypokalemia (low potassium), and short-term memory loss. Following a fall, the resident's service plan was updated to include assistance with dressing, grooming, toileting, bathing, and escort assistance. The resident's assessment indicated the resident was alert and oriented, had chronic pain, self-administered medications, transferred independently, and utilized a 4-wheel walker, and a wheelchair for long distances.

The incident report indicated the resident fell in her bathroom when attempting to place a toilet paper roll on the dispenser.

The resident's record indicated following the fall; staff arranged for the resident to be evaluated at a hospital. The resident required stitches in two areas on her arm and had a skin abrasion to a shin. The resident returned to the facility the same day and licensed staff added wound care services, toileting assistance, and staff escorts, to the resident's plan of care. The resident's record indicated licensed and unlicensed staff provided wound care and the arm wounds healed without complication. The resident's record indicated five weeks after the fall the shin abrasion developed signs of infection. Licensed staff contacted the resident's family who agreed to contact the resident's provider for an antibiotic and scheduling a visit with the provider. The next day, a family member brought the resident to a hospital for an evaluation of the leg wound. The resident received an order for antibiotics and returned to the facility.

Hospital records indicated the resident was seen twice within five weeks. The first emergency room visit included a computed tomography (CT) head scan, stitches in the arm, and a skin abrasion noted to the shin. The resident was treated and discharged back to the facility the same day. Hospital records indicated the resident was seen a second time for symptoms of infection to the shin and reported to hospital personnel the shin wound had improved since the first emergency room visit. Hospital records indicated a diagnosis of cellulitis (a bacterial infection that affects the skin) in the left leg and antibiotics were ordered. A few hours after arriving at the emergency room, the resident discharged back to the facility.

Review of the services provided documentation indicated staff provided the resident with toileting assistance and escorts with a four wheeled walker and/or wheelchair for long distances according to her assessed needs.

During an interview, unlicensed staff stated she worked night shifts most of the time and assisted the resident back to her room after the emergency room visit for the fall. Unlicensed staff stated the resident had been sent to the emergency room after the fall because of a bump on her forehead. The unlicensed staff stated she did not recall if the resident received stitches at the emergency room and had not worked a shift in the resident's area of the facility for a week or more after the fall. The unlicensed staff stated all unlicensed personnel were trained for wound care upon hire, however, wound care was not typically done on the night shift.

During an interview, licensed staff stated the resident was mainly independent with activities of daily living (ADL's) until a fall resulted in skin injuries. Following the fall, wound care services, toileting assistance, and escorts were added to the resident's care plan. Licensed staff stated the resident self-administered medications and nursing concerns were discussed with the resident's family about adding medication administration as a service for the resident which would allow licensed staff to monitor antibiotic use, however, the service was declined. Licensed staff stated family had the resident seen by a provider sometime during the five weeks prior to the second emergency room visit and the resident had been prescribed antibiotics, however, because the resident self-administered medications licensed staff could not confirm the antibiotics had been taken as ordered and had not received paperwork from the visit. Licensed staff stated the arm wounds healed, however, during a shin bandage change five weeks after the initial fall, signs of infection were observed, and licensed staff recommended the resident be taken to the emergency room. Licensed staff stated the resident received another round of antibiotics from the emergency room visit and within a few weeks the wound was healed.

During interview, the resident stated staff took good care of her and the wounds were healed.

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: Attempted.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed and reassessed the resident's wounds. The facility provided wound care and added additional services to support the resident's needs.

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
	20074	A. BUILDING: _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	600 PARK STREET EAST ANNANDALE, MN 55302

(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 *****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: #HL200748222M/#HL200744621C On January 8, 2025, 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 23 residents receiving services under the assisted living license. The following correction orders are issued for #HL200748222M/#HL200744621C, tag identification 1960 and 2310.	0 000	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.	
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 1 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 document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed and if not administered, the reason why they were not provided was documented for one of one resident (R1) reviewed with wounds managed by the provider. 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: R1's assessment dated September 16, 2024 indicated R1's diagnoses included wound care. R1 required assistance with dressing, toileting, incontinence cares, hygiene, and escorts. R1 had wounds managed by facility nurses and wound care provided by unlicensed personnel	01960		

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01960	Continued From page 2 (ULP's). A progress note dated September 17, 2024, indicated wound care was ordered twice a day and PRN (as needed) for the right forearm, elbow and shin. R1's Plan of Care logs dated September 1, 2024, through September 30, 2024, indicated R1 received wound care to the right forearm, elbow and shin twice daily and as needed (PRN). Shin wound care documentation was not completed on September 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 2024, ten out of fifteen scheduled times. A progress note dated September 25, 2024, indicated the right forearm and elbow were healed and wound services for those areas were discontinued. The right shin wound care was continued. R1's Plan of Care logs dated October 1, 2024, through October 31, 2024, indicated R1 received wound care to the right shin twice daily and PRN. A progress note dated October 9, 2024, indicated the right shin wound measured 1.8 centimeters (cm) x 1.3 cm and the registered nurse (RN) would monitor weekly until healed. A progress note dated October 21, 2024, indicated the right shin wound appeared infected, the provider was updated and antibiotics were requested. A progress note dated October 22, 2024, indicated R1 was seen at the emergency room (ER) and the provider ordered a 10-day course of antibiotics.	01960		

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01960	Continued From page 3 A progress note dated October 29, 2024, indicated right shin wound measured 1 cm x 1 cm, no signs of infection and wound care to continue as ordered, every other day until healed. A progress note dated November 4, 2024, indicated right shin wound improved. Course of antibiotics completed. A progress note dated November 12, 2024, indicated right shin wound healed and wound care discontinued. On January 9, 2025, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated she was unsure of why the services were not signed off as completed and was unaware R1's shin wound care had not been activated in the electronic system for ULP's from September 16, 2024, to September 26, 2024. The licensee's Medication, Treatment and Therapy Administration by Unlicensed Personnel policy updated September 2019, indicated the RN monitored and supervised the staff to ensure tasks were carried out as directed. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01960		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 4 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one residents (R1) who required wound care. 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: R1's record lacked evidence a registered nurse (RN) completed a wound assessment or was aware of two wounds on R1's left lower shin/top of foot and behind R1's right knee. On January 8, 2025, at 11:50 a.m., the investigator observed unlicensed personnel (ULP)-D escort R1 from the dining room to the bathroom and assist with toileting services. The investigator observed a cotton ball taped to the back of R1's right knee region with white first aide tape and a second 4x4 white gauze pad taped to the lower left shin/top of foot region. The bandages were not dated or initialed and ULP-D stated she was unaware of when the bandages were placed on R1 or what the bandages were for. ULP-D removed the taped cotton ball from behind R1's knee region and observed a 1"	02310		

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02310	Continued From page 5 circular skin tear. ULP-D covered the wound with a Band-Aid and stated she would notify a nurse. R1's progress notes dated September 1, 2024, through January 8, 2025, did not include information related to R1's two observed wounds. On January 8, 2025, at 2:30 p.m., the investigator asked registered nurse (RN)-C if ULP-D had notified her of R1's wounds and bandages. Initially RN-C stated she had no knowledge of the wounds or bandages, a short time later RN-C stated she had misspoke and may have been notified with a note, or verbally the day prior. The investigator observed RN-C search a shred box for a note, however, RN-C was unable to locate a note. RN-C reviewed R1's progress and triage notes with the investigator and stated triage had not been notified and R1's progress notes did not contain any information about the new wounds. RN-C stated CNS-B oversaw that area of the facility. On January 8, 2025, at 3:10 p.m., the investigator asked clinical nurse supervisor (CNS)-B if she was aware R1 had two bandages placed on her. CNS-B stated she was unaware and went to R1's room with the investigator for observation. CNS-B observed a Band-Aid placed behind R1's right knee area and a 4x4 gauze bandage (neither dated or initialed) on R1's lower left shin/top of foot area. CNS-B asked R1 what happened and R1 stated to CNS-B that nurses (referring to ULP's) had put them there during the night two days earlier. CNS-B stated it was policy for bandages to have a date and initials when placed on a resident. The licensee's Communication policy dated October 2019, indicated caregiver staff were to	02310		

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02310	Continued From page 6 report all changes in status of resident's to oncoming shift by documenting on a 24 hour report sheet. Report sheets were reviewed by nurses who would document and follow up when needed. The licensee's Charting policy dated September 2019 indicated progress notes would include charting on injuries and the charting would ensure consistent cares for the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02310		