Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259972100M
Compliance #: HL259979943C

Date Concluded: May 21, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Detroit Lakes the Cottage
1435 Madison Ave.
Detroit Lakes, MN 56501
Becker County

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the facility failed to provide accurate medication administration and wound care management as prescribed. The resident did not receive ordered barrier cream to prevent skin breakdown for a resolved pressure ulcer. As a result, the resident's pressure ulcer re-opened.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident's medication administration record lacked orders for prescribed barrier cream twice daily, the resident's services indicated the resident received the barrier cream as prescribed. When interviewed the resident's family and facility staff indicated the resident had chronic recurring pressure ulcer areas, and there were no concern the resident had not received wound care management as ordered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the residents pressure ulcer areas.

The resident resided in an assisted living facility secure memory care unit with diagnoses including weakness and localized edema.

The resident's assessment indicated the resident was cognitively impaired, but able to make his needs known. The assessment indicated the resident had thin fragile skin and utilized pressure relieving devices. The assessment indicated the resident received medication management and administration services and was being treated for decubitus ulcers on his sacrum and hips.

The resident's orders indicated the resident had utilized mepilex dressings for wound care of the resident's pressure ulcer areas. The resident's provider discontinued the mepilex dressing and ordered barrier cream to be applied twice daily and as needed for skin integrity.

The facility investigation indicated when nursing placed the order for the resident's barrier cream it was checked for self-administer instead of scheduled for staff to administer on the medication administration record (MAR). The facility investigation identified the resident received barrier cream as prescribed on the service agreement.

The resident's service/care plan included orders for the barrier cream to be applied twice daily and as needed. The resident's service delivery of care record indicated the resident received the barrier cream as prescribed.

The resident's progress notes indicated the resident received wound care, wound monitoring, and various interventions to prevent recurring worsening pressure ulcers.

When observed the resident appeared to have two small superficial denuded (loss of epidermis caused by prolong moisture and friction) areas covered by barrier cream. The resident denied discomfort and indicated the areas were always in the same spot and would come and go.

When interviewed staff stated the resident had barrier cream in his room that was applied twice daily and as needed as indicated in the service agreement. Staff stated they would alert nursing staff if there was any change or worsening of the areas.

When interviewed nursing staff stated the resident had chronic recurring pressure ulcer areas that never completely resolved, and they had no concern the resident had not received the barrier cream as prescribed.

When interviewed the resident's family stated they had no concerns regarding the residents wound care not being completed. The family member stated the resident's pressure ulcers were chronic and recurring over the last few years and never fully 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, attempted.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility audited resident orders to ensure accuracy, provided the nurse with additional order entry training, and added the resident's barrier cream to the MAR to ensure accurate scheduled administration.

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
	25997	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN DETROIT LAKES THE COTTAGE	1435 MADISON AVENUE DETROIT LAKES, MN 56501

(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 April 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL259972100M/#HL259979943C. No correction orders are issued.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	