Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL267541500M
Compliance #: HL267549063C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Villages of Lonsdale
1000 Birch Street Northeast
Lonsdale MN, 55046
Rice County

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

Evaluator's Name: Kris Detsch, 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 a resident when they failed to assess the resident's skin. As a result, the resident acquired cellulitis (infection) of her leg, and a skin rash to her buttocks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. A physician discovered the resident had cellulitis of her leg and provided an antibiotic medication. The facility administered the medication and evaluated her response to the medication. At the time, the resident lived in the assisted living area of the facility. Approximately, one month later, the resident became ill with Covid 19 then transferred into the memory care unit of the facility. The next morning, staff discovered redness of her buttock skin and provided medical care.

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 resident records, and employee files. Also, the investigator

toured the facility and observed documentation systems, medication administration, the secured unit, and interactions between staff and residents.

The resident resided in an assisted living facility in her own apartment but eventually transferred into the facility's memory care unit. The resident's diagnoses included dementia, anxiety, hypertension. The resident's service plan included assistance with medications, meals, housekeeping, safety checks, and dressing. The resident's nursing assessment indicated she walked independently and toileted herself. She required staff to remind and encourage her to do good hygiene. She was alert, but forgetful and confused.

During an interview, a nurse said the resident sustained a small skin tear on her lower leg. She washed the area and applied a band-aid. The nurse said the resident was able to communicate her needs and did not complain of pain. The nurse said staff did not report any further concerns to her about the resident's skin.

The resident's medical record indicated she went to see her physician approximately two weeks later. The records indicated her family brought her to the physician to evaluate her memory. During the exam, the physician observed the resident's leg and noticed she had redness and swelling of her skin, but there were no open wounds. The physician diagnosed her with cellulitis and gave her an antibiotic medication.

Progress notes indicated a nurse noticed the resident's skin remained red after she completed the antibiotic medication and informed the physician. The physician gave the resident another antibiotic medication. Approximately one month later, resident became ill with Covid 19 and moved into memory care. The following day, the resident did not want to get out of bed, eat, or drink. The nurse observed the resident's skin and noticed redness on her buttocks. The resident's skin condition deteriorated. Her skin blistered and the redness spread to her legs.

During an interview, the nurse manager said the resident became ill with Covid 19. During this time, a staff member told her the resident's skin on her buttocks appeared red, so she went and looked at her skin. She told the staff to keep her skin dry and linins off her, but an hour later, the redness spread through her buttocks and leg. The manager said she called the resident's family, then sent the resident to the hospital. The resident returned the same day.

Hospital records indicated the resident had erysipelas (bacterial infection). They gave the resident antibiotic medications and returned her to the facility.

During an interview, a family member said the resident recovered from her skin infections. The resident's family moved her into a different facility.

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: No, unable due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility coordinated medical care with the resident’s physician.

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
	26754	A. BUILDING: _____ B. WING _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGES OF LONSDALE LLC	1000 BIRCH STREET NORTHEAST LONSDALE, MN 55046

(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 May 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL267549063C/#HL267541500M. No correction orders are issued.	0 000		