Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302321944M
Compliance #: HL302323672C

Date Concluded: November 23, 2022

Name, Address, and County of Licensee Investigated:

Birchwood Arbors
750 1st St NE 218
Forest Lake, MN 55025
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Substantiated, facility responsibility

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 a resident when they failed to assess the residents' recurring complaints of left foot and toe pain for several weeks. The resident developed a wound between the toes on his left foot that became infected, and the resident was transferred to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident complained of left foot pain for several weeks, however, the facility failed to ensure the residents skin was assessed. The resident's left toe became purple and swollen, and the following day the resident complained of severe foot pain. The resident had signs of infection and a deep, dime size wound between his toes. The resident was transferred to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of facility policies and procedures, the resident's progress notes, medication and treatment administration records, service plan, services received record, hospital, clinic, and emergency room after visit summaries. Also, the investigator observed other residents in the facility.

The resident's record indicated the resident was diabetic, legally blind and required assistance with dressing, and bathing twice per week.

The resident resided in an assisted living facility with diagnoses including diabetes, legal blindness, and chronic kidney disease. The resident's service plan included assistance with dressing and bathing twice weekly. The resident assessment indicated the resident was cognitively intact, able to make his needs know, and did not identify and pressure ulcers or diabetic vascular wounds.

The resident was seen by podiatry for routine nail care about one month prior to the incident. At that time no issues were identified with the resident's skin.

The resident's services received report indicated the month of the resident's foot pain the resident received assistance with bathing three times. The resident record lacked any documentation of routine skin monitoring completed prior to the wound being identified.

The resident's progress notes indicated the first documented complaint of foot pain occurred on the 7th of the month, however, there was no corresponding documentation regarding an assessment of the resident's foot pain. 14 days later the residents progress notes indicated the resident again had complained of foot pain. The note indicated the resident had neuropathy, and indicated the resident's left foot was more swollen, with purple or darker skin on the 4th toe of the left foot. The note failed to indicate an assessment of the area was completed. The following day, 15 days following the resident's first documented report of foot pain, indicated the resident had severe complaints of foot pain. The note indicated when the area was assessed the resident's foot was swollen on the top with a pink streak from the 4th toe to the ankle. The note indicated the resident had dried blood between his 4th and 5th toes on the left foot and indicated when the area was cleansed a dime size open area approximately 3 centimeters (cm) deep was noted. The resident was transferred to the hospital.

The resident record indicated the resident was admitted to the hospital and diagnosed with a diabetic ulcer and a cellulitis infection. The record indicated the resident received intravenous and oral antibiotics and required daily wound care.

When interviewed the resident's family member indicated the resident had complained daily of foot and toe pain for weeks. The family member indicated she had reported the concern to the

facility, but they failed to follow up and assess the area. The family member stated weeks went by without the facility following up, and the resident developed a serious ulcer and infection in his left toe/ foot area. The family member indicated the resident's wound had still not healed almost 4 months later.

When interviewed a facility unlicensed staff member stated she recalled the resident having Neuropathy (numbness) in his feet. The staff member stated she had assisted the resident with bathing and stated she did not dry or look between the resident's toes; however, she did not notice anything unusual.

When interviewed a nurse stated she recalled looking at the resident's feet but did not notice the ulcer between the resident's toes. The nurse indicated if she had inspected the resident's feet, she would have documented it in a progress note.

When interviewed leadership staff stated they had identified concerns regarding lack of assessment after the resident reported foot pain. The leadership staff indicated staff should have thoroughly inspected the resident's foot and toes after reporting pain.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, declined.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
Once the wound was identified the facility ensured the resident received follow up care and wound care. The facility identified the resident was not thoroughly assessed when he had complained of foot pain. Education was provided to licensed and unlicensed staff on skin care, skin monitoring/inspection, reporting changes, ulcerations, and documentation. Audits were completed to ensure competency, with plans for ongoing staff training.

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 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Forest Lake City Attorney
Forest Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30232	A. BUILDING: _____ B. WING _____	C 10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD ARBORS	750 NE 1ST STREET FOREST LAKE, MN 55025

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On October 31, 2022, the Minnesota Department of Health conducted a complaint investigation for HL302321944M, and HL302323672C at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 37 residents receiving services under the provider's Assisted Living license. The following correction orders were issued for HL302321944M, and HL302323672C, tag identification 2360.	0 000	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was neglected. Findings include: On October 31, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and the facility was responsible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	