Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331635388M
Compliance #: HL331637390C

Date Concluded: December 18, 2024

Name, Address, and County of Licensee Investigated:
Ultimate Care Group Inc.
7931 6th Street NE
Spring Lake Park, MN 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, 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 cares in accordance with the resident's plan of care. The resident presented to an emergency department with pressure injuries on her low back (sacrum) and heels, along with hardened feces on her buttocks and stomach feeding tube. In addition, the resident's urine was cloudy and thick in the resident's urine collection bag. The resident was diagnosed with a urinary tract infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff followed the resident's plan of care at the time she was hospitalized which included daily catheter care. There was no evidence in the resident's hospital record indicating the resident had pressure sores or feces on her body or urinary tubing when she arrived at the emergency department. The facility appropriately sent the resident to the emergency department when the resident experienced a change in condition. The resident was diagnosed with a urinary tract infection, received treatment, and returned to her baseline health.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's legal guardian. The investigation included review of the resident's facility record, hospital record, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's catheter cares while onsite.

The resident resided in an assisted living facility. The resident's diagnoses included history of urinary tract infections, difficulty swallowing (dysphagia), and stroke. The resident's care plan indicated she received daily catheter cares and repositioning every two hours. At the time of the investigation, the resident had a surgically placed feeding tube in her stomach for nutrition and medications. In addition, the resident had a surgically placed urinary tube (supra pubic catheter) inserted in her lower stomach to drain urine from her bladder. The resident was considered a vulnerable adult but there were no signs of abuse or neglect. The resident was mostly non-verbal but was able to make her needs known with simple yes and no questions. The resident used a mechanical (Hoyer) lift for transfers and an electric wheelchair for mobility.

The resident's hospital record indicated one day the resident presented to an emergency department to be evaluated for generalized weakness and decreased oral intake. A physical exam performed by a doctor indicated the resident's skin was cool, dry, and intact. There was a loose dressing surrounding the resident' suprapubic catheter with a small amount of purulent (pus) drainage from the catheter. The hospital doctor documented no further complaints or concerns regarding the resident. The resident was diagnosed with a urinary tract infection and aspiration pneumonia (lung infection caused by breathing in food or liquid into the lungs). The resident was treated with antibiotics for the urinary tract infection and pneumonia. During the hospitalization, a feeding tube was placed in the resident's stomach for nutrition and medications. The resident was discharged back to the facility ten days later.

The resident's hospital record lacked evidence the resident had any pressure sores or dried feces on her body.

A facility nurse stated staff repositioned and cleaned around the resident's tubes daily and stated the resident did not have any pressure sores.

During an interview, the resident's legal guardian stated she was upset to hear the facility was being investigated about the resident's cares. The resident's guardian stated she never had concerns about the facility and was happy with the cares the resident received from facility staff. The guardian stated the facility always kept her informed and up to date on the resident's condition.

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 to interview due to being mostly non-verbal.
Family/Responsible Party interviewed: Yes. The resident's legal guardian was interviewed.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the emergency department when she experienced a change in condition.

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
	33163	A. BUILDING: _____ B. WING _____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE CARE ASSISTED LIVING SPRING LAKE HOUSE	7931 6TH STREET NE SPRING LAKE PARK, MN 55432

(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 November 22, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL331637390C/#HL331635388M. No correction orders are issued.	0 000		