DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369846604M
Compliance #: HL369849903C

Date Concluded: March 28 , 2025

Name, Address, and County of Licensee Investigated:
Midwest Residential Inc
10449 Johnson Ave S
Bloomington, MN, 55437
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
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 the facility staff failed to provide routine cares to the resident. The resident developed bed sores on his buttocks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had bed sores when the resident admitted to the facility. The facility offered appropriate cares, however the resident at times stated he would do them himself or refuse the cares. The cares the resident did allow, the facility provided.

The investigator conducted interviews with administrative staff and nursing staff. The investigation included review of the resident record, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia (paralysis that affects the lower half of the body), neuromuscular dysfunction of bladder (lack of

bladder control), neurogenic bowel (loss of normal bowel function), and pressure ulcers (localized damage to the skin and/or underlying tissue). The resident's service plan included assistance with medication and treatment management, behavioral management, and wound care. The resident's assessment indicated the resident was alert and oriented, used a wheelchair, could self-transfer, and performed self-catheterization.

A concern arose the resident was not receiving essential services, such as grooming and toileting. The concern indicated as a result of not receiving these services the resident had developed severe bed sores on his butt.

Progress notes indicated the resident refused wound care and said he would complete it himself seven days in a two-and-a-half-month period. The progress notes indicated the resident would leave the facility without notifying staff, sometimes for a couple of days. The progress notes also indicated the resident would go to the hospital without the staff's knowledge.

The medication passing detail record for wound care indicated wound care was scheduled two times a day. The record indicated the resident refused wound care thirty-two times and was not in the facility to receive the scheduled wound care seventy-six times over a two-and-a-half-month period.

A hospital discharge record indicated the resident had not allowed the nurse to do wound care and would not allow the provider to check the wound. The record indicated the resident said he could change the dressing himself. The record also indicated the resident had hospital stays for frequently for infections, both wound and urinary tract, and sepsis (serious condition in which the body responds improperly to an infection). The record indicated multiple urinary tract infections in past month likely related to straight catheterization, with poor infection control technques.

During an interview, the family member stated the resident told them staff where not changing his brief, so he had to sit in stool while in his wheelchair. The family member stated the resident was not incontinent of urine. The family member stated the resident was able to transfer to and from the wheelchair independently. The family member did not know if the resident refused wound care. The family member stated the resident left the facility often to go to the store and visit family and sometimes the resident would stay overnight with family.

During an interview, the nurse stated the resident was independent with urine and bowel care. The nurse stated all staff were trained to do wound care, including unlicensed caregivers. The nurse stated the resident's wounds were monitored by a wound clinic, but he missed a lot of visits because he was hospitalized or out of the facility.

During an interview, a manager stated the resident was able to self-transfer and independent with bed mobility. The manager stated the nurse would do the morning wound care and unlicensed caregivers would do the evening wound care, when the resident

allowed them too. The manager stated the resident had scheduled wound care clinic visits every month. The manager stated it was difficult to provide the resident with cares because of refusals and often in and out of the hospital. The manager stated he would leave the hospital against medical advice too.

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, attempted but did not reach.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	36984	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST RESIDENTIAL INC	10449 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437

(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 March 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL369849903C / #HL369846604M. No correction orders are issued.	0 000		