Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393709242M
Compliance #: HL393707881C

Date Concluded: May 27, 2025

Name, Address, and County of Licensee Investigated:
Adequate Home Care LLC
10255 Madison Street Northeast
Blaine, MN 55434
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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 alleged perpetrator (AP) neglected the resident when the resident developed multiple pressure wounds.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and AP were responsible for the maltreatment. The AP, who was also the owner and registered nurse, failed to provide care and schedule two staff necessary to maintain the resident's health and safety. The resident admitted to the facility with a coccyx wound and closed pressure wounds on both heels. During the resident's five-month admission, he developed four new wounds to his lower legs, and his coccyx wound worsened throughout his admission. The resident also developed osteomyelitis (bone infection) in two wounds. The resident's assessments indicated he required assistance from two staff for repositioning as he was a large person. Likewise, the hospital record required two staff assistance for repositioning every two hours. The AP

scheduled one staff on all shifts and expected the staff member call the AP when a second staff was needed for transfers and incontinence cares but not for repositioning. In addition, the resident assessment indicated staff would attend appointments with the resident, but the AP failed to ensure interventions were carried out to prevent pressure injuries to legs directed to the AP during the appointments.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed family members, case manager, and the resident's wound care specialist. The investigator also interviewed staff from his previous facility and current facility as he no longer resided at Adequate Home Care LLC. The investigation included review of the resident's medical records, hospital records, personnel files, staff schedules, photos of the pressure wounds, and related facility policy and procedures

The resident's assessments at his previous facility, before being admitted to Adequate Home Care LLC, indicated he required two to three staff assist for transfers and repositioning.

The resident resided in an assisted living facility. The resident's diagnoses included chronic atrial fibrillation (irregular heartbeat), cerebellar stroke syndrome, and epileptic syndrome with simple partial seizures. The resident's service plan included assistance with medication administration, grooming, dressing, incontinence cares, activities, bathing, safety checks, and transferred with a mechanical full body lift.

The resident's assessment indicated the resident required total assistance from two staff for dressing twice a day, grooming twice a day, bathing three times a week, incontinent cares three to six times a day, repositioning every two hours, one to one staff to provide one hour activity daily, one staff to continually monitor resident while he was in his wheelchair, and safety checks every thirty minutes while in bed.

The resident's support plan, completed by the AP for payment, indicated the resident required total care from two staff for cares including dressing morning and night, showers three times a week, incontinence care twice daily and as needed for bowel movements, repositioning every two hours, and two staff for full body mechanical lift transfers. This "will require a third staff" as a standby assist. The assessment indicated the resident required safety checks every 30 minutes while in bed and will sit within line of sight while in wheelchair. The resident required staff to set up appointments and attend appointments with the resident.

The resident's service delivery record (services the resident received and signed by staff after service is completed) failed to include turning and repositioning. Also, the service delivery record only included safety checks completed once a day every Tuesday.

The hospital record indicated the resident was a total assist and required two staff to turn and reposition him every two hours. Education was provided to facility staff on wound care and interventions to promote healing. Four and a half months after the resident was admitted to

the facility, he was sent to the hospital for the second time. At that time, the hospital record indicated the resident's wounds had worsened and four new wounds were assessed. The hospital took photos of the wounds. The hospital record indicated the resident was "not doing well at current group home, now with many pressure sores."

During an interview, the AP said the resident required total assist with cares including medication management, tube feeding, incontinence cares, and transfers. The AP scheduled one staff per shift and when a second staff was needed for mechanical full-body lift transfers and incontinence cares the staff member at the facility called the AP or owner-2. The AP and owner-2 lived three-minutes (by car) away from the facility. He said the resident admitted to the facility with a wound on his coccyx. He said the resident acquired two wounds while at the facility located on the side of each leg. He said the wounds formed from rubbing against his wheelchair. The resident was in his wheelchair for extended periods during wound care, speech, and medical appointments. When asked what interventions were implemented to prevent his legs from rubbing against the sides of the wheelchair the AP said Mepilex (thick spongy bandage) was applied to the area, blankets wrapped around the resident, pillows placed, and foam wraps applied around his leg. He said the resident's family member brought him to appointments and failed to protect his legs from rubbing against the wheelchair. He said all the wounds developed from equipment, not from lack of repositioning. He said the pillows placed under the resident's legs during appointment would shift and get lost so his leg would continually rub against his wheelchair. He later said he attended all the wound care appointments with the resident and the dates of his speech appointments were after his pressure wounds had developed.

During an interview, an unlicensed staff member said two staff members worked on each shift while the resident lived there. She said the resident needed two staff to provide services. After MDH investigator informed her the facility schedule was reviewed, the unlicensed staff said only one staff was scheduled each shift. The resident was transferred into his wheelchair during shift change, when day shift staff arrived and again when evening shift staff arrived since two staff were available. The AP went to the facility at dinner time to assist with resident transfer back into wheelchair for a meal. The resident was assisted back to bed when the night shift arrived. She said sometimes one staff would reposition the resident and sometimes two staff.

The wound specialist, who worked at the hospital and provided outpatient wound care to the resident, said the resident had one open wound located on his coccyx when he was admitted to the facility. The wound specialist saw the resident four times since he admitted to the facility. The first time she saw him was a month and a half after he admitted to the facility. At that time, he had a coccyx wound, a wound on his left heel that was almost healed, and a wound on his right heel that was closed. He also had scabbed areas on both legs in the front of his ankle area. During this first appointment, she completed extensive education on interventions to promote healing and prevent further tissue damage with the AP and the resident's family member. The education included proper repositioning to prevent pressure areas. No further follow up appointments were scheduled at that time. She said six weeks later the wife scheduled an

appointment, reporting his wounds had worsened and new wounds had developed. At this second appointment, the resident had two new open pressure wounds on his right leg. One wound was where he had the previous scab at his last appointment. The wound specialist was concerned about the new wounds but said they looked very healable. Two weeks later at his third appointment, a third pressure wound on his right leg was identified, and he still had one on his right heel (still closed), left heel open, and they arrived late so she was unable to assess his coccyx wound. One month later, during his fourth appointment, the wounds on his right lower leg were all dead tissue. Two of his three pressure wounds had merged into one much larger and deeper wound. The left shin had a deep tissue wound (closed). His coccyx wound was "much, much bigger." He also had new wounds on the outside of his left leg, and they were black, "100 percent dead tissue." She was "shocked" and said his wounds looked "horrible." The wife reported she was concerned about the resident's care and reported when she brought this up to the AP, he called her "stupid." The AP reported he had no idea how he was getting all these wounds except for the left shin wound was caused by transferring him in the full body lift. During the resident's transfer back to his wheelchair, the AP showed the wound specialist how the resident's leg touched the lift bar. The wound specialist was concerned about the amount of time the resident was "hanging in this lift." She said he had to have been there for a long time to cause a pressure injury. She said if the facility followed the interventions in place including repositioning every two hours properly (as trained) and Prevalon boots on while in bed his wounds would have healed. The wounds were caused from extended pressure against the area, either from the resident's positioning in the wheelchair or lying in bed without Prevalon boots on. Staff could have seen his leg pressing against his wheelchair and easily prevented pressure to those areas. She said she pointed it out during one of his early appointments. The resident was very large and required two staff to properly reposition him every two hours. The resident's wounds would have healed had the AP implemented the interventions according to the plan of care. Education was provided to the AP on wound care and interventions to prevent pressure areas at all wound appointments.

During an interview, family member-1 said the AP failed to provide the care the resident needed. She said the resident had no wounds when he admitted to the facility and within a couple weeks the resident developed multiple wounds. She said she visited frequently and only one staff worked at a time. During one visit, she was there for five hours, and the resident was never repositioned. When she requested the staff member reposition him, the staff member said she needed to wait for another staff to come to the facility as he was too large for her to move alone. She expressed several concerns to the AP during the resident's stay including staffing, wounds, repositioning, and the resident not wearing his required pressure reducing Prevalon boots when ordered. The resident was seven feet tall and heavy. She said the AP continued to schedule only one staff despite the inability for one staff to provide the required care the resident required to maintain his health and safety.

During an interview, family member-2 said when she visited, she observed only one staff at the facility. She said the resident was not repositioned per his care plan which caused the resident to develop multiple wounds. The AP refused to listen to family members concerns including

failure to provide care according to the resident's care plan including number of staff required to provide care, therapy appointments cancelled by the AP, and failure to reposition the resident per his care plan. She said the wound care specialist expressed concern about the care the resident received at the facility after the resident developed several pressure wounds. The resident was observed multiple times without his pressure reducing Prevalon boots. The resident required two staff for cares and three staff for transfers. She said during a meeting with the AP, case manager, and family members, the case manager inquired about the number of staff working compared to the number of staff assistance indicated on the resident's assessment.

During an interview, the resident's case manager said the AP completed an assessment of the resident's required care which included the number of staff needed to provide his care. The assessment determined the financial payment the facility received based on the resident's services. The case manager said the expectation of the facility was to provide the services indicated on the assessment, including number of staff required to provide the resident's care. The resident required two staff for most services and a third staff member as a stand-by assist during full body transfers. The facility should have staff according to the assessments.

During an interview, the owner of the previous facility the resident lived at before being admitted to Adequate Home Care LLC said the resident required two to three staff assist for repositioning every two hours. She said he was very large and exhibited aggressive behaviors during cares at times. He was hard to reposition safely with one staff member. She said the resident had a small, reddened area (sheering) on both sides of his buttocks from incontinence when he was admitted. She said his right heel was reddened with a small area of black skin and his left heel had an abrasion (sheering). She said the areas were healing during his stay. The resident did not develop any new wounds during his two-month stay.

During an interview, the nurse where he currently resided (after discharge from Adequate Home Care LLC) said the resident lived at the facility for one month. The resident had five wounds when he was admitted, one on his coccyx, two on his left leg and two on his right leg. He said both heel wounds, left and right were closed upon admission and remained closed. He said the resident's coccyx wound depth had decreased but the area was relatively unchanged. He said one of the wounds on his left leg healed and the other three wounds on his legs have decreased in size. The nurse reported the wound measurements upon admission and current measurements. All wound sizes decreased since he arrived at this new facility one month ago.

In conclusion, the Minnesota Department of Health determined 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 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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP directed an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility and the AP failed to provide adequate staffing levels.

The AP followed the facility directive and/or policies and procedures.

The AP had the authority to direct and implement operational regulatory requirements or make operational changes.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility attended wound care appointments.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

You may also call 651-201-4200 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
Anoka County Attorney
Blaine City Attorney
Blaine Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 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: HL393707881C/HL393709242M On May 5, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were two residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL393707881C/HL393709242M, tag identification 2360.	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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

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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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		