Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273782584M
Compliance #: HL273784400C

Date Concluded: April 19, 2023

Name, Address, and County of Facility Investigated:
Inver Grove Heights White Pines
9058 Buchanan Trail
Inver Grove Heights, Minnesota
55076-3554
Dakota County

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

Evaluator's Name: James P. Larson
Special Investigator

Finding: Not Substantiated

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.

Allegation(s): The facility neglected the client when the client experienced wounds on his buttocks of unknown origin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident sustained wounds on his buttocks, when areas of skin concern were observed, facility staff reported the findings to the resident's primary care team. Facility staff assessed, monitored, and implemented additional interventions to facilitate wound healing.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator also conducted an interview with the resident's family. The investigation included review of the resident's medical record, nursing assessments, service plans, care plans, and progress notes. The investigator conducted an onsite visit and observed staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a stage 4 buttocks pressure injury, Dementia, and failure to thrive. The resident's service plan included assistance with medication administration, activities of daily living, housekeeping, and meals.

The resident was able to ambulate with the use of assistive devices, including a two wheeled walker and a standard wheelchair. The resident's nursing assessments prior to the injury indicated the resident frequently refused to follow recommendations from staff to promote skin integrity.

Review of resident progress notes indicated when staff first identified a possible skin injury on the resident's tailbone area (approximately the size of the dime), staff began monitoring the area and notified the resident's physician and family. The resident's physician examined the area and ordered additional treatment to be provided from an advanced medical team. The resident received wound care from facility nursing staff and an outside agency. Despite these treatments, the wound advanced in size and severity and the resident was later transferred to a local hospital for a higher level of care.

After a week-long stay in the hospital where he received advanced wound care, the resident returned to the facility with orders for facility staff to change the wound dressing three times a week and as needed.

Additionally, upon discharge from the hospital, a hospice consult was recommended due to the resident's advanced stage of Dementia. The resident was assessed, admitted to hospice care, and passed away weeks later.

During an interview with a nurse at the facility, she stated that upon discovery of the pressure injury, an internal quality assurance investigation was completed to ensure proper care was provided and identify if there was a need for additional training.

During an interview with the resident's family member, they stated they had received updates on the resident's condition throughout his stay at the facility and had no additional concerns with his care.

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 (Deceased)
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the incident to the Minnesota Department of Health (MDH) and the resident's primary care team. The facility also conducted an internal investigation of the incident.

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
	27378	A. BUILDING: _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(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 LICENSING 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: #HL273783252C/ #HL273781703M #HL273784400C/ #HL273782584M On March 8, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 42 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL273783252C/ #HL273781703M, tag identification 0250, 0620, 0720 and 1350. On March 8, 2023, the Minnesota Department of Health initiated an investigation of complaint # HL273784400C /HL273782584M. No correction orders are issued.	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 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.	

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0 250	Continued From page 1	0 250		
0 250 SS=A	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250		

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0 250	Continued From page 2 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to fully cooperate with an inspection, survey, or investigation as evidenced by failure comply with records requested. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 8, 2023, Licensed Assisted Living Director (LALD)-A was sent a request to provide facility records,	0 250		

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0 250	Continued From page 3 including a copy of the facilities policy titled Incident Report. The facility did comply with other record requests for policies throughout the investigation but failed to provide the investigator with Title of Policy 2.25 Incident Report as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report a physical injury of unknown origin to the Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 620		

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0 620	Continued From page 4 of the residents). Findings include: During the entrance conference on March 8, 2023, Licensed Assisted Living Director (LALD)-A was sent a request to provide facility records for R2. R2's diagnoses included Dementia with Lewy bodies, orthostatic hypotension and epilepsy. R2's service plan dated March 4, 2022, indicated R2 received services to include medication administration, assistance with activities of daily living (ADLs), housekeeping, and meals. Review of R2's electronic health record (EHR) progress notes dated Tuesday May 31, 2022, indicated on Saturday May 28, 2022, family had visited R2. When family returned the next day on Sunday May 29, 2022, R2 had bruising around the left eye. A nurse made an entry into R2's EHR on Tuesday May 31, 2022, at 9:51 AM that an internal investigation would begin and that family members of R2 were notified that an unwitnessed incident had occurred over the weekend. Subsequently, a delay in reporting occurred and a report was not submitted to MAARC until Tuesday May 31, 2022. During an interview with the Licensed Assisted Living Director (LALD) she confirmed on Sunday May 29, 2022, outside agency staff were scheduled to be assigned to care for R2. The LALD confirmed the temporary agency staff failed to fill out and submit the proper incident report to nursing or facility leadership over the weekend.	0 620		

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0 620	Continued From page 5 The facility's Incident Reporting (Involving Clients, Independent Residents visitors, and Staff) policy was also requested. This was not provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 720 SS=A	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure appropriate records were readily available to the Minnesota Department of Health (MDH) surveyor during an onsite investigation. The Licensed Assisted Living Director (LALD)-A was unable to provide contact information for outside agency temporary staff who were scheduled during May 2022. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 720		

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0 720	Continued From page 6 of staff are involved, or the situation has occurred only occasionally). The findings include: During the onsite investigation on Monday March 8, 2023, LALD A was sent a request to provide facility records for agency staff scheduled during May 2022. LALD A was able to produce a three-ring binder with current temporary staff information. Although, for two unlicensed professionals (ULP)-H and ULP-I as well as Licensed Practical Nurse (LPN)-J a document was produced which contained only the name of the staffing agency and office phone number. During an interview with the Licensed Assisted Living Director (LALD) she confirmed she did not have the requested information and had attempted to contact the staffing agencies on March 8, 2022, and was denied the contact information requested from the agency operators. No further information was provided. Time Period to Correct: Seven (7) Days	0 720		
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the unlicensed facility staff failed to report a physical	01350		

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01350	Continued From page 7 injury of unknown origin to nursing and facility leadership for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During the entrance conference on March 8, 2023, Licensed Assisted Living Director (LALD)-A was sent a request to provide facility records for R2. R2's diagnoses included Dementia with Lewy bodies, orthostatic hypotension and epilepsy. R2's service plan dated March 4, 2022, indicated R2 received services to include medication administration, assistance with activities of daily living (ADLs), housekeeping, and meals. Review of R2's electronic health record (EHR) progress notes dated Tuesday, May 31, 2022, indicated on Saturday May 28, 2022, family had visited R2. When family returned the next day on Sunday, May 29, 2022. R2 had bruising around the left eye. A nurse made an entry into the EHR on Tuesday, May 31, 2022, at 9:51 AM that an internal investigation would begin and that family members of R2 were notified an unwitnessed incident had occurred over the weekend.	01350		

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01350	Continued From page 8 During an interview with the Licensed Assisted Living Director (LALD)-A she confirmed on Sunday, May 29, 2022, outside agency staff were scheduled to be assigned to care for R2. The LALD A confirmed the temporary agency staff failed to fill out and submit the proper incident report to nursing or facility leadership over the weekend. The facility's Incident Reporting (Involving Clients, Independent Residents visitors, and Staff) policy was also requested. This was not provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01350		