Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL325395423M
Compliance Project: HL325397542C

Date Concluded: September 23, 2024

Name, Address, and County of Licensee Investigated:
Chaska Heights Senior Living
3120 N Chestnut St
Chaska, MN 55318
Carver County

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

Evaluator's Name: Lena Gangestad, 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 the facility did not care for and/or change the wound dressing, leading to an infected wound with extensive tissue damage and exposure of the tendon.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although there was a delay in wound care, this was caused by miscommunication between the facility and the home care agency. Once the issue was identified, the facility sent the resident to the hospital for evaluation appropriately.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator unbale to reach the resident's family member. The investigation included review of resident's records, facility's policies and

procedures, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses pressure ulcer wound of the left lateral leg full thickness. The resident's service plan included transfer with assist if two persons with full body mechanical lift. The facility did not provide wound care services but contracted these out to home care agencies.

A concern arose the resident admitted to the facility but had not received wound cares as ordered by the medical provider. About 11 days after admission, the resident was sent to the hospital for further evaluation.

A facility nursing assessment indicated the facility faxed the referral for wound care to the home care service the day before the resident's planned admission. The same document indicated this was also verbally discussed with the home care agency.

The resident's progress notes indicated the home care agency nurse arrived on the 11th day after admission to provide wound cares, however the resident initially refused cares. The same document indicated a facility nurse provided assistance and the resident did agree to allow the wound to be assessed. Upon viewing the wound, the home care nurse recommended further evaluation and the facility sent the resident to the emergency room for evaluation.

During an interview, a home care nurse stated she visited the resident to start her care. Although the resident initially refused to let her examine the wound, the nurse insisted and eventually inspected it. When she removed the dressing, which was dated nearly two weeks earlier, and having a discussion with manager #1 they decided to send the resident to the hospital for further evaluation. The nurse stated she was unfamiliar with the scheduling and admission to home health care process, so she did not know why the resident's cares were delayed in starting home care services.

During an interview, manager #1, who was also a nurse, stated she stated that she conducted a pre-assessment for the resident while at the nursing home, received the report, and was aware of the wound on the resident's ankle. Manager #1 did not examine the wound herself but only saw the dressing although the nursing home told her it was a stage 2 wound. Manager #1's stated the referral for wound care was faxed to the home care agency the day before the resident admitted to the facility. She stated she confirmed the fax had been received. After the resident was admitted, she went up to the resident's apartment and checked the dressing, which was clean, dry, and intact. Manager #1 stated she was unaware of the delayed start of service as there was no communication between the facility and home health care agency. During the delay, the facility caregivers checks the dressing but did not raise any concerns regarding it.

The facility's internal investigation included comments from multiple caregivers who stated they observed the resident's dressing which was dry and intact.

A review of the resident's medical record did not identify communication between the home care agency and the facility regarding the initial delay of cares.

During the interview, manager #2 stated she was aware of the incident involving the resident. She explained that after the incident, the facility implemented a tracking system for referrals to ensure timely care and reduce risks associated with delays. The facility also purchased miscellaneous wound care supplies for use as needed and educates all staff on skin conditions and reportable concerns. Manager #2 stated the facility also implemented a 24-hour report for listing all wounds for follow-up, and weekly skin assessments for residents with skin concerns or wounds.

The resident returned from hospital with a new referral for wound cares with the home care agency, which were completed as ordered.

During the interview, the resident did not remember much about the incident. She said she loved the staff and the care she received at the facility.

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: Yes.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented a tracking system for referrals to ensure timely care and reduce risks associated with delays. The facility also purchases miscellaneous wound care supplies for use as

needed and educates all staff on skin conditions and reportable concerns. All wounds will now be listed on the 24-hour report for follow-up, and weekly skin assessments will be conducted for all residents with skin or wound conditions.

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
	32539	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASKA HEIGHTS SENIOR LIVING	3120 CHESTNUT STREET NORTH CHASKA, MN 55318

(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 September 10, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL325395423M/HL325397542C . No correction orders are issued.	0 000		