MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202308668

Date Issued: February 23, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

The Cottages of Dakota Commonwealth
13421 Commonwealth Dr.
Burnsville, MN 55337

Eriksmoen Cottages
1513 Southcross Dr. W.
Burnsville, MN 55306

License Number and Program Type:

1072534-H_CRS (Home and Community-Based Services-Community Residential Setting)
1072531-HCBS (Home and Community-Based Services)

Investigator(s):

Christine Henne/Alice Percy
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
Christine.Henne@state.mn.us
651-431-3444

Suspected Maltreatment Reported:

It was reported that a staff person (SP) left a vulnerable adult (VA) in his/her bed for hours and did not reposition the VA every two hours as required, resulting in pressure sores. The SP did not ensure that the VA was given regular meals and when s/he fed the VA, s/he gave the VA large amounts of food on the spoon to "hurry" him/her.

Date of Incident(s): Ongoing, prior to October 12, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (a):

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 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 which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on November 16, 2023; from documentation at the facility and medical records; and through twelve interviews conducted with two facility administrative staff persons (P1 and P8), six staff persons (P2 – P7), the SP, a health care professional (HCP), the VA, and the VA's family member (FM).

The VA enjoyed going on community outings, playing games, listening to music, and spending time with family members. The VA's diagnoses included multiple sclerosis, neurogenic bladder, osteoporosis, and a seizure disorder. The VA used a wheelchair for mobility. The VA was not under guardianship.

According to the VA's *Intensive Support Self-Management Assessment*, the VA did not have dietary restrictions, but preferred to eat healthy food. The staff persons cut the VA's food into small pieces and assisted the VA with eating. The VA required assistance when moving between his/her bed and his/her wheelchair.

The VA stated that s/he liked living at the facility and the staff persons were "very nice." The food at the facility was "very tasty" and the staff persons assisted the VA with eating. If the staff persons fed the VA too fast, the VA asked them to slow down, which they did. The VA did not recall any instance where s/he choked from being fed too fast. The VA did not recall any occasions when s/he did not get a meal. The staff persons typically assisted the VA from his/her bed to his/her wheelchair each morning. The VA sometimes wore the same clothing for two days and was "okay" with doing so. At one time, the VA's "tailbone" was not "healing right" and the VA remained in his/her bed for longer periods of time. When the VA was in his/her bed, the staff persons repositioned the VA every 30 to 45 minutes. If the VA needed assistance while s/he was in his/her bed, s/he called for the staff persons to come assist him/her.

The FM provided the following information:

- On the afternoon of October 8, 2023, the FM visited the VA at the facility. The VA was lying in his/her bed and wearing the same clothing s/he wore the previous day. The staff persons told the FM that they left the VA in his/her bed that day. The VA told the FM s/he did not have lunch that day. The FM stated that when s/he visited the VA on weekends, the two staff persons working at the facility were often looking at their cell phones or sitting rather than assisting the residents. The FM frequently brought up his/her concerns to the administrative staff persons.

- On October 9, 2023, the FM received a telephone call from the HCP, who treated the VA's pressure wounds. The HCP told the FM that the VA had "horrific" wounds on his/her buttocks that had developed since the previous Monday when the HCP last visited the VA. The HCP told the FM that the change in the VA's condition was "directly related" to the staff persons leaving the VA in his/her bed for the entire weekend and

not repositioning the VA as required.

- The previous month, the VA had e-coli in his/her urine, which the FM believed was caused by the staff persons not changing the VA's colostomy bag in a sanitary manner. On one occasion, the FM went to the facility and found the VA in his/her wheelchair with "drool" coming out of his/her mouth. The VA was calling for assistance from the staff persons, but the staff persons did not respond until the FM asked them for assistance. The SP was "aggressive" when assisting the VA with eating and attempted to "ram" food into the VA's mouth. The SP did not always cut the VA's food in small pieces.

The HCP provided the following information:

- The HCP worked with the VA for several months on wound care and catheter management and typically saw the VA every Monday. In early October 2023, the VA had one pressure wound on his/her coccyx that was improving. The HCP stated that the VA's pressure wound was "chronic" and had originated in July 2019. On October 9, 2023, the HCP went to the facility to work with the VA and found that the chronic pressure wound was unchanged, but the skin on the VA's coccyx was "terrible." The HCP believed it was because the VA had not been repositioned as required over the weekend. The HCP stated that both sides of the VA's buttocks were "very red." The HCP believed that s/he measured the skin breakdown "as part of the coccyx wound, but it was the skin around the coccyx." The HCP believed the skin breakdown could occur in a short period of time. The VA's skin breakdown "would come and go," but the HCP did not recall it previously being "that bad." On September 25, 2023, the HCP documented that the area of skin breakdown on the VA's coccyx measured 0.4 x 0.5 centimeters (cm) and the area was "light pink" and "looked good." On October 9, 2023, the HCP documented that the area was 7.5 x 7.5 cm and the area was bleeding. The HCP telephoned the FM to ask him/her to purchase a medicated cream that the VA needed. The FM told the HCP that s/he had concerns about the VA not being repositioned over the weekend.

- The staff persons were supposed to reposition the VA every two to three hours. They were also supposed to apply a prescribed cream to the area and apply a barrier film to the surrounding skin to protect the area. The HCP changed the VA's catheter every other week and the staff persons emptied and cleaned the ostomy bag as needed.

P1 – P8, the SP, and the facility's documentation provided the following information:

- Consistent information was provided that the VA was unable to reposition him/herself and was unable to move his/her body without assistance. The VA relied on the staff persons to bathe, feed, and administer medications to him/her. Because the VA had a history of skin breakdown, the staff persons were trained to reposition the VA every two hours. The VA liked to get out of bed each morning and move to his/her wheelchair. When the VA was in his/her wheelchair, the staff persons frequently adjusted the wheelchair and tilted it back and forth so that s/he did not sit in one position for long periods of time. The staff persons typically assisted the VA out of his/her bed by 9 a.m. each morning and back into his/her bed by 8 p.m. If the VA was in his/her bedroom, the staff persons were trained to check on the VA every 30 minutes. The VA was also able to call for assistance from the staff persons and had a "call button" to push when s/he needed assistance. P6 stated that after the staff persons assisted the VA into bed each night, they put pajamas on the VA and checked his/her pressure wound. They then cleaned the area, applied cream, and placed the wound patch over the pressure wound. P7 stated that the VA had a pressure wound on his/her coccyx "for years."

At times the pressure wound healed and at other times it got worse. When it was worse, the VA's doctors and nurses told the staff persons what to do to help the VA heal. P1 stated that there were typically two or three staff persons working at the facility during the day and one staff person working the overnight shift.

- P2 stated that on October 5, 2023, s/he worked at the facility and the skin on the VA's coccyx was "fine." P1 stated that on October 6, 2023, a home-care nurse (N) checked on the AV's pressure wound. At that time, the VA's skin on his/her buttocks was "looking great" and there was "just red skin." P6 stated that the skin around the VA's pressure wound was "looking much better." P2 stated that on October 7, 2023, s/he worked at the facility, but s/he did not see the VA's coccyx area. P4 stated that on October 7, 2023, at approximately 6 or 7 p.m., P4 and the SP provided care to the VA's pressure wound. P4 wiped the area around the pressure wound. P4 stated that at that time, the VA's coccyx area looked the same as it had in the past.

- P3 stated that on October 8, 2023, s/he worked at the facility, but did not see the VA's wound because the SP and P6 worked with the VA that day. P3 did not know if either P6 or the SP checked the VA's pressure wound. Neither P6 nor the SP mentioned anything to P3 about the VA's pressure wound. P6 stated that s/he did not know "what happened" with the VA's pressure wound because s/he was not present when it became worse. P5 and the SP stated that each day the staff persons checked the VA's pressure wound, cleaned it, applied a cream, and then covered it. P3 and P4 each stated that the staff persons typically checked the VA's pressure wound each day, applied creams to the area, and then applied a wound patch.

- On October 9, 2023, both P1 and P2 worked at the facility. The HCP arrived at the facility to check on the VA and found the area around the VA's coccyx to be bleeding from an open sore. P2 stated that s/he assisted the HCP with changing the wound patch and saw a round wound that had a "tiny hole the size of a pin" and around the hole was a "very red" area that was approximately six inches wide. The HCP telephoned the FM to inform him/her about the pressure wound and P1 talked to all of the staff persons who worked with the VA over the weekend. P1 believed that something occurred on Saturday night to "aggravate" the VA's skin and cause an open sore. P1 stated that there were two pressure wounds on the VA's tailbone "right next to each other" that were the size of two quarters. After the pressure wounds were found, the VA had a "virtual visit" with the VA's wound care physician.

- P1 stated that s/he had no previous concerns about the care the SP gave to the residents. The SP had worked with the VA for three years prior to the incident. P3, P4, P5, and P7 each stated that they never saw any staff person, including the SP, treat the VA or other residents "roughly" or fail to provide personal cares correctly. P6 stated that the SP cleaned and treated the VA's pressure wound as they were trained and s/he never saw the SP handle the VA or other residents roughly. The SP stated that s/he did not treat the VA in a rough manner and never saw any other staff person be rough with the residents.

- P1 did not have any concerns about the VA not getting enough food, because the VA was "very vocal" about what s/he wanted to eat. If the VA were to refuse a meal, the staff persons documented it. Occasionally, the staff persons "rushed" the VA when feeding him/her because the VA took longer to chew due to wearing dentures. At those times, P1 reminded the staff persons to be mindful of how they fed the VA. P2, P5 and P6 had no concerns about any of the staff persons feeding the VA too fast. P2, P3, P4, P6, and the SP each stated that the VA sometimes "forgot" s/he ate a meal. P7 stated that the VA "ate everything" when P7 worked at

  the facility. The SP stated that the VA was a "good eater." The SP stated that s/he fed the VA "like a baby"

and gave the VA time to chew the food between bites.

- P2 and the SP each stated that the staff persons changed the VA's clothing each day and were unaware of any times when the VA's clothing was not changed. P7 stated that the staff persons changed the VA's clothing every morning and evening.

According to the VA's *Medication Administration Record (MAR)*, the staff persons were to complete the VA's colostomy care three times daily and reposition the VA fourteen times daily and document that in the MAR. On October 7 and 8, 2023, the staff persons documented that they repositioned the VA every two hours and provided colostomy care three times.

According to the *Patient Information Report*, on October 9, 2023, the HCP documented that, "Wound to coccyx looks ok, but surrounding skin is significantly worse. There is open raw areas on either side of sacrum, looks suspicious of being on [his/her] back for too long without pressure relief. [Staff person] helping with positioning during wound care asked [the VA] if [s/he] got out of bed yesterday and [VA] said that [s/he] did not get out of bed. . . [The FM] said that [s/he] was over to visit [the VA] yesterday in the afternoon. [The VA] was in [his/her] bed and said [s/he] had not been out of bed all day."

According to the facility's *TLogs*, on October 8, 2023, at 8 p.m., P3 documented, "[The VA] was in the living room at the start of the shift, received [his/her] regular meds, ate supper, visited by [the FM], now in bed sleeping." At 6 p.m., P5 documented, "When changing [the VA's disposable brief] in the evening I noticed that the wound was getting bad and the cream which we use, it is finished and maybe the other cream is being used so I don't know what is the problem."

According to the staff schedule, on October 7, 2023, the SP worked from 7 a.m. to 9 p.m., P2 worked from 7 a.m. to 1 p.m., P4 worked from 3 to 10 p.m., and P6 worked from 10 p.m. to 7 a.m. On October 8, 2023, the SP worked from 7 a.m. to 10 p.m., P3 worked from 7 a.m. to 9 p.m., P6 worked from 7 a.m. to 1 p.m. as well as 10 p.m. to 7 a.m., and P5 worked from 3 p.m. to 8 p.m.

Facility documentation showed that the SP and P1 – P8 each received training on the Reporting of Maltreatment of Vulnerable Adults Act, on the facility's policies, and on the VA's plans prior to the incidents.

Conclusion:

On October 6, 2023, the N checked on the VA's pressure wound and found that the skin on the VA's buttocks was "looking great." On October 9, 2023, the HCP checked on the VA's pressure wound and found that the chronic pressure wound was unchanged, but the skin on the VA's coccyx was "terrible." The VA's skin breakdown "would come and go," but the HCP did not recall it previously being "that bad." On October 7 – 8, 2023, six staff persons worked at the facility. While P5 documented on October 8, 2023, at 6 p.m., that the VA's wound was "getting bad," up to that point none of the other staff persons had concerns about the VA's pressure wound and surrounding area. The VA had a history of skin breakdown and the HCP stated that the VA's pressure wound was "chronic" and the VA's skin breakdown "would come and go,"

It was also reported that the SP did not regularly provide food to the VA and when s/he assisted the VA with eating, s/he placed large amounts of food in the VA's mouth in order to "hurry" the VA. P1 did not have any

concerns about the VA not getting enough food, because the VA was "very vocal" about what s/he wanted to eat. P1 stated that occasionally, the staff persons "rushed" the VA when feeding him/her because the VA took longer to chew due to wearing dentures. At those times, P1 reminded the staff persons to be mindful of how they fed the VA. None of the staff persons had concerns about anyone feeding the VA too fast. Several staff persons stated that the VA sometimes "forgot" s/he ate a meal. The SP stated that when s/he fed the VA, s/he gave the VA time to chew the food between bites.

Although it was concerning that the VA's pressure wound and surrounding area worsened over the weekend of October 7 – 8, 2023, the staff persons documented that they followed the VA's physician's recommendations concerning the VA's skin care over the weekend, including repositioning the VA every two hours. Given that no information was provided that the staff person failed to complete the VA's pressure wound care or failed to reposition the VA as required and that none of the staff persons had concerns about the VA not getting enough to eat or being fed too fast, there was not a preponderance of the evidence as to whether there was a failure to provide the VA with care or services which were reasonable and necessary to maintain the VA's physical or mental health or safety.

It was not determined whether neglect occurred (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 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 which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that the facility's policies were adequate, but were not followed by the staff persons. After the incidents, the staff persons received additional training on wound care and on assisting the VA with eating. The SP no longer worked at the facility.

Action Taken by Department of Human Services, Office of Inspector General:

No further action taken.