MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Accurate Home Care LLC
9000 Quantrelle Ave NE
Otsego, MN 55330
Wright County

Report#: H8129009

Date: February 2, 2017

Date of Visit: February 2-3, 2016
Time of Visit: 2:00 p.m.-4:15 p.m.
8:00 a.m.-4:30 p.m.

By: Jane Aandal, RN, Special Investigator

Type of Facility: ☐ Nursing Home ☐ SLF ☐ Hospital ☒ HHA ☐ ICF/IID ☐ Other: _____ ☐ Home Care Provider

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that a patient was neglected when a staff, alleged perpetrator unsafely transferred patient, dumping water on his/her face. Emergency response was called, CPR was initiated, and the patient was admitted to hospital for pneumonia.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☑ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) did not follow the patient's care plan and did not initiate cardiopulmonary resuscitation (CPR) when the client experienced respiratory distress.

The patient had quadriplegia and was ventilator dependent. The patient's plan of care indicated the patient was a full code and had an emergency protocol in place. The care plan had an emergency airway clearance protocol including using a manual resuscitation bag (a pump device to assist ventilation) with 100% oxygen, irrigating with saline, and suctioning. If there was no result with those actions, staff were to call 911. Staff were to continue to use the bag until help arrived or the situation resolved.

On the evening of the incident, the AP transferred the patient to bed with a mechanical lift. The patient requested that the AP hook-up the humidification to the tracheostomy prior to removing the lift sling. Because the sling was still under the patient, the AP turned the patient from side to side. The humidifier on the bedside table tipped over causing water to back up into the humidifier tubing. The AP attempted to shake the water out of the tubing and elevated the head of the bed, but the patient was not getting enough air. The patient requested the AP ventilate with the bag. The AP did not comply, but instead went upstairs to get the family member. When the AP and the family member returned to downstairs, the patient was unresponsive and did not have a pulse. The family member suctioned the patient, used the bag, and did chest compressions. The AP did not assist with CPR. A second family member came to assist. The second family member provided the backup ventilator and suctioned the patient. The first family member called 911, and then the AP took over CPR. During this time, the AP was unable to find a pulse. The patient went to the hospital and was admitted for a one day with a diagnosis of aspiration pneumonia.

The family member interview indicated the patient was not to have the humidification tubing hooked up until the sling was out from underneath him/her. The family member stated when they came downstairs the ventilator was off.

The alleged perpetrator (AP) participated in an interview. The AP stated s/he had received training specific to this patient's care plan. The AP indicated s/he did not start providing ventilation with the manual resuscitation

bag, because the patient had a pulse. However, resuscitation can be provided regardless of the status of the patient's pulse.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ individual(s) and/or ☐ facility is responsible for the
☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:
The facility had policies and procedures in place for the patient when an emergency situation occurred. The facility had trained the staff in all aspects of the patient's care. The staff did not follow the emergency procedures.

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.

Compliance:

Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) – Compliance Not Met
The requirements under Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Statutes for Home Care Providers (MN Statutes, section 144A.43-144A.483) – Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43-144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(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:

(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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records
☐ Care Guide
☐ Medication Administration Records
☐ Treatment Sheets
☒ Facility Incident Reports
☐ Physician Progress Notes

☐ ADL (Activities of Daily Living) Flow Sheets
☐ Laboratory and X-ray Reports
☐ Physician Orders
☐ Social Service Notes
☐ Nurses Notes
☐ Meal Intake Records
☐ Activities Reports
☐ Weight Records
☐ Therapy and/or Ancillary Services Records
☐ Assessments
☐ Skin Assessments
☒ Care Plan Records
☐ Service Plan
☐ Other, specify: _____

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☐ Resident/Family Council Minutes
☒ Personnel Records/Background Check, etc.
☒ Staff Time Sheets, Schedules, etc.
☐ Facility In-service Records
☒ Facility Internal Investigation Reports
☒ Facility Policies and Procedures
☐ Call Light Audits
☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility Report

If unable to contact complainant, attempts were made on:

Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: Unable to remember the incident

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 1

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 2

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☐ Safety Issues	☐ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☒ Use of Equipment	☐ Transfers	☐ Incontinence

☐ Call Light ☐ Other: _____

Was any involved equipment inspected: ○ Yes ◉ No ○ N/A Specify: _____

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A Specify: _____

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Nursing
The Office of Ombudsman for Long-Term Care
Wright County Sheriff
Wright County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248129	A. BUILDING _____ B. WING _____	C 04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURATE HOME CARE LLC	9000 QUANTRELLE AVE NE OTSEGO, MN 55330

(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) COMPLETION DATE
G 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #H8129009 and #H8129010. As a result, the following deficiencies are issued related to #H8129009.	G 000		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on interview and document review, it was determined that the agency failed to ensure compliance with the Condition of Participation of Skilled Nursing Services at 42 CFR 484.30. The agency failed to ensure staff provided emergency care in accordance with a patients plan of care. As a result, the Condition of Participation of Skilled Nursing Services at 42 CFR 484.30 is not met. Findings include: Based on interview and document review, the licensee failed to ensure that 1 of 3 patients (P1) received care and services according to the patient's plan of care when the patient experienced respiratory distress and emergency services were not provided in accordance with the plan of care.The patient was hospitalized for aspiration pneumonia. See G170.	G 168		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on interview and document review, the	G 170		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 170	Continued From page 1 licensee failed to ensure that 1 of 3 patients (P1) received care and services according to the patient's plan of care when the patient experienced respiratory distress and emergency services were not provided in accordance with the plan of care.The patient was hospitalized for aspiration pneumonia. Findings include: P1's medical record was reviewed. P1 was diagnosed with quadriplegia and acute respiratory failure which required a tracheostomy (surgical opening into the windpipe) placement. P1 was ventilator dependent. The care plan dated 11/15/15 to 11/14/16 indicated that P1 was a full code and requested CPR. The care plan directed staff during a life threatening emergencies to call 911. The care plan had an emergency airway clearance protocol which included to bag (ambu bag, a pump device to assist ventilation) the patient with 100% oxygen, irrigate with saline, bag and suction. If there was no result with that action, staff were to call 911. The protocol directed staff to remove the trach tub, insert a new current size trach and continue to bag with the highest oxygen flow through the trach. The care plan instructed staff to repeat the bagging, irrigation and suctioning but not to change the trach again. Staff were instructed to continue to bag until help arrived or the situation resolve. An Incident Report dated 12/23/15, indicated licensed practical nurse (LPN)-B transferred P1 to bed at 11:30 p.m. and connected P1 to the main ventilator with humidification. LPN-B turned P1 onto his side to remove the sling from	G 170		

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G 170	Continued From page 2 underneath the client. LPN-B heard a noise and the humidifier had tipped on its side. LPN-B tried to empty the water trap to get rid of the excessive water. P1 asked LPN-B to "bag him." LPN-B got the ambu bag (a pump device to assist ventilation) however, LPN-B did not use the ambu bag on P1 prior to going upstairs to get P1's family member (FM)-E. P1 was breathing at this time LPN-B left to get FM-E.. When FM-E arrived downstairs P1 was unresponsive and not breathing so FM-E started to ventilate P1 with the ambu bag while LPN-B checked for a pulse. LPN-B was unable to find a pulse and FM-E started chest compressions. FM-E went upstairs to get FM-F. LPN-B continued to ventilate with the ambu bag and do chest compressions. FM-F came downstairs and found the suction machine was not working properly so the filter was changed and FM-E suctioned P1. The primary ventilator was not working so FM-F switched P1 to the backup ventilator. FM-E called 911 while LPN-B ventilated with the ambu bag and did compressions. FM-F suctioned for secretions. The police arrived along with the ambulance about five minutes later. The automatic external defibrillator (AED) was applied and a pulse was found. P1 was transferred to the hospital and treated for aspiration pneumonia. The Patient Journal dated 12/24/15, indicated FM-E called the agency and spoke to registered nurse (RN)-C. FM-E reported the nurse drowned P1 last night. There was water in the humidifier tubing that went into P1's lungs. The nurse panicked and went to get FM-E. When FM-E returned P1 had no pulse or respirations. FM-E called 911, suctioned P1 and did chest compressions. When first responders arrived P1 had a pulse but was still unresponsive. FM-E	G 170		

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G 170	Continued From page 3 stated P1 was sent to the hospital for pneumonia. An interview was conducted with the agency director on 2/3/16, at 10:04 a.m. The director stated LPN-B should have suctioned P1 when water went into the humidifier tubing. In addition, LPN-B should have ventilated P1 with the ambu bag and provided CPR per P1's emergency protocol and care plan. An interview was conducted with FM-E on 2/12/16, at 12:50 p.m. FM-E stated when LPN-B came upstairs she stated P1 was having some problems and did not portray the incident as major. FM-E stated when she got downstairs P1 was unresponsive, did not have a pulse, and the ventilator was not on. FM-E stated she suctioned P1 and went to put the ventilator on and it did not work due to water entering the ventilator. FM-E asked FM-F to switch the ventilator to the backup ventilator. FM-E stated she did chest compressions and the ambu bag and also called 911. FM-E stated the incident should never have happened if LPN-B would have removed the sling prior to putting the humidification on the humidifier it would not have tipped over. An interview was conducted with LPN-B on 2/19/16, at 11:03 a.m. LPN-B stated she arrived at P1's home on 12/23/15, at 9:00 p.m. LPN-B stated she transferred P1 to bed with the mechanical lift. LPN-B stated P1 used humidification at night so she hooked the tubing to P1's tracheostomy. LPN-B stated then she turned P1 onto his side to remove the sling and the humidifier tipped over and water backed up into the humidifier tubing. LPN-B stated she was shaking the water out of the tubing and elevated P1's head of his bed. LPN-B stated P1 was not	G 170		

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G 170	Continued From page 4 getting enough air and asked LPN-B to "bag him." LPN-B went upstairs to get FM-E as there was no phone downstairs. LPN-B stated she told FM-E to come downstairs right away as she needed help with P1. LPN-B stated she did not ventilate P1 with the ambu bag as requested prior to going upstairs to get FM-E because P1 had a pulse. LPN-B stated she probably should have suctioned P1 prior to going upstairs to get FM-E, but felt she needed more people to help. LPN-B stated P1 wanted the humidification hooked up prior to having the sling removed so she complied. LPN-B stated she was overly tired. LPN-B stated she did not notify the agency after the incident. LPN-B stated she did not holler upstairs for FM-E as she felt FM-E would not hear her. LPN-B stated she did not suction P1 as FM-E and FM-F did the suctioning. LPN-B further stated she did ventilate P1 and do chest compressions when FM-E went upstairs to call 911. LPN-B stated she checked P1's pulse 4-5 times when FM-E went to get FM-F and found no pulse. The licensee's policy titled, Admission to Services revised 7/31/15, indicated services and cares requested must conform to current standards of practice for the respective discipline and the service to be provided should be reasonable and necessary to the treatment of the patient's medical illness or injury.	G 170		

Minnesota Department of Health

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	H21487	A. BUILDING: _____ B. WING _____	C 04/25/2016

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0 000	Initial Comments A complaint investigation was conducted to investigate complaint #H8129009 and #H8129010. The following correction orders are issued related to #H8129009.	0 000	Tag numbers have been assigned to Minnesota state Statutes for Home Care Providers. 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 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal "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 surveyors' 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.	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;	0 325		

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0 325	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that 1 of 1 client (C1) was free from maltreatment-neglect when the patient experienced respiratory distress and cardiac arrest without licensed nursing staff initiating cardiopulmonary resuscitation (CPR). The patient was hospitalized one day for aspiration pneumonia. This practice resulted in a level 3 violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment or death) and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed. C1 was diagnosed with quadriplegia and acute respiratory failure which required a tracheostomy (surgical opening into the windpipe) placement. C1 was ventilator dependent. The care plan dated 11/15/15 to 11/14/16 indicated that C1 was a full code and requested CPR. The care plan directed staff during a life threatening emergencies to call 911. The care plan had an emergency airway clearance protocol which included to bag (ambu bag, a pump device to assist ventilation) the patient with 100% oxygen, irrigate with saline, bag and suction. If there was no result with that action, staff were to call 911. The protocol directed staff to remove the trach tub, insert a new current size trach and continue to bag with the highest oxygen flow through the trach. The care plan instructed staff to repeat the bagging, irrigation and suctioning	0 325		

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0 325	Continued From page 2 but not to change the trach again. Staff were instructed to continue to bag until help arrived or the situation resolve. An Incident Report dated 12/23/15, indicated licensed practical nurse (LPN)-B transferred C1 to bed at 11:30 p.m. and connected C1 to the main ventilator with humidification. LPN-B turned C1 onto his side to remove the sling from underneath the client. LPN-B heard a noise and the humidifier had tipped on its side. LPN-B tried to empty the water trap to get rid of the excessive water. C1 asked LPN-B to "bag him." LPN-B got the ambu bag (a pump device to assist ventilation) however, LPN-B did not bag C1 prior to going upstairs to get C1's family member (FM)-E. C1 was breathing at this time LPN-B left to get FM-E. When FM-E arrived downstairs C1 was unresponsive and not breathing so FM-E started to ventilate C1 with the ambu bag while LPN-B checked for a pulse. LPN-B was unable to find a pulse and FM-E started chest compressions. FM-E went upstairs to get FM-F. LPN-B continued to ventilate with the ambu bag and do chest compressions. FM-F came downstairs and found the suction machine was not working properly so the filter was changed and FM-E suctioned C1. The primary ventilator was not working so FM-F switched C1 to the backup ventilator. FM-E called 911 while LPN-B ventilated with the ambu bag and did compressions. FM-F suctioned for secretions. The police arrived along with the ambulance about five minutes later. The automatic external defibrillator (AED) was applied and a pulse was found. C1 was transferred to the hospital. The Patient Journal dated 12/24/15, indicated FM-E called the agency and spoke to registered nurse (RN)-C. FM-E reported the nurse drowned	0 325		

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(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
0 325	Continued From page 3 C1 last night. There was water in the humidifier tubing that went into C1's lungs. The nurse panicked and went to get FM-E. When FM-E returned C1 had no pulse or respirations. FM-E called 911, suctioned C1 and did chest compressions. When first responders arrived C1 had a pulse but was still unresponsive. FM-E stated C1 was sent to the hospital for pneumonia. An interview was conducted with the agency director on 2/3/16, at 10:04 a.m. The director stated LPN-B should have suctioned C1 when water went into the humidifier tubing. In addition, LPN-B should have ventilated C1 with the ambu bag and provided CPR per C1's emergency protocol and care plan. An interview was conducted with FM-E on 2/12/16, at 12:50 p.m. FM-E stated when LPN-B came upstairs she stated C1 was having some problems and did not portray the incident as major. FM-E stated when she got downstairs C1 was unresponsive, did not have a pulse, and the ventilator was not on. FM-E stated she suctioned C1 and went to put the ventilator on and it did not work due to water entering the ventilator. FM-E asked FM-F to switch the ventilator to the backup ventilator. FM-E stated she did chest compressions and the ambu bag and also called 911. FM-E stated the incident should never have happened if LPN-B would have removed the sling prior to putting the humidification on the humidifier it would not have tipped over. An interview was conducted with LPN-B on 2/19/16, at 11:03 a.m. LPN-B stated she arrived at C1's home on 12/23/15, at 9:00 p.m. LPN-B stated she transferred C1 to bed with the mechanical lift. LPN-B stated C1 used humidification at night so she hooked the tubing	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21487	A. BUILDING: _____ B. WING _____	C 04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURATE HOME CARE LLC	9000 QUANTRELLE AVE NE OTSEGO, MN 55330

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0 325	Continued From page 4 to C1's tracheostomy. LPN-B stated then she turned C1 onto his side to remove the sling and the humidifier tipped over and water backed up into the humidifier tubing. LPN-B stated she was shaking the water out of the tubing and elevated C1's head of his bed. LPN-B stated C1 was not getting enough air and asked LPN-B to "bag him." LPN-B went upstairs to get FM-E as there was no phone downstairs. LPN-B stated she told FM-E to come downstairs right away as she needed help with C1. LPN-B stated she did not ventilate C1 with the ambu bag as requested prior to going upstairs to get FM-E because C1 had a pulse. LPN-B stated she probably should have suctioned C1 prior to going upstairs to get FM-E, but felt she needed more people to help. LPN-B stated C1 wanted the humidification hooked up prior to having the sling removed so she complied. LPN-B stated she was overly tired. LPN-B stated she did not notify the agency after the incident. LPN-B stated she did not holler upstairs for FM-E as she felt FM-E would not hear her. LPN-B stated she did not suction C1 as FM-E and FM-F did the suctioning. LPN-B further stated she did ventilate C1 and do chest compressions when FM-E went upstairs to call 911. LPN-B stated she checked C1's pulse 4-5 times when FM-E went to get FM-F and found no pulse. The licensee's policy titled, Admission to Services revised 7/31/15, indicated services and cares requested must conform to current standards of practice for the respective discipline and the service to be provided should be reasonable and necessary to the treatment of the patient's medical illness or injury. The licensee's policy titled, Patient Abuse,	0 325		

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0 325	Continued From page 5 Neglect or Exploitation - Adult implemented 5/13, indicated the following. Accurate Home Care is committed to promoting an abuse, neglect, or exploitation free environment to the nest of its ability for all patients receiving care, treatment and/or services. To demonstrate support for the patient's right to be free from mental, physical, sexual and verbal abuse, neglect, or exploitation. To demonstrate support for the patient's right to safety. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 325		
0 805	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report to the common entry point (CEP) as required by state law an allegation of maltreatment/neglect when nursing staff failed to initiate cardiopulmonary resuscitation 1 of 3 clients (C1) allegations reviewed. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety, but had the potential to have harmed a client's health or safety), and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed. C1 was diagnosed with quadriplegia and acute respiratory failure which required a tracheostomy (surgical	0 805		

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0 805	Continued From page 6 opening into the windpipe) placement. C1 was ventilator dependent. An Incident Report dated 12/23/15, indicated licensed practical nurse (LPN)-B transferred C1 to bed at 11:30 p.m. and connected C1 to the main ventilator with humidification. LPN-B turned C1 onto his side to remove the sling from underneath the client. LPN-B heard a noise and the humidifier tipped on its side. LPN-B tried to empty the water trap to get rid of the excessive water. C1 asked LPN-B "bag him." LPN-B got the ambu bag (a pump device to assist ventilation) however, LPN-B did not bag C1 prior to going upstairs to get C1's family member (FM)-E. C1 was breathing at this time. When FM-E arrived downstairs C1 was unresponsive and not breathing so FM-E started to ventilate C1 with the ambu bag while LPN-B checked for a pulse. LPN-B was unable to find a pulse and FM-E started chest compressions. FM-E went upstairs to get FM-F. LPN-B continued to ventilate with the ambu bag and do chest compressions. FM-F came downstairs and found the suction machine was not working properly so the filter was changed and FM-E suctioned C1. The primary ventilator was not working so FM-F switched C1 to the backup ventilator. FM-E called 911 while LPN-B ventilated with the ambu bag and did compressions. FM-F suctioned for secretions. The police arrived along with the ambulance about five minutes later. The automatic external defibrillator (AED) was applied and a pulse was found. C1 was transferred to the hospital. An interview was conducted with LPN-B on 2/19/16, at 11:03 a.m. LPN-B stated she did not notify the agency when the incident occurred with C1. LPN-B stated FM-E notified the agency and the agency contacted LPN-B five days later.	0 805		

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0 805	Continued From page 7 An interview with registered nurse (RN)-D clinical manager was conducted on 2/2/16, at 3:00 p.m. RN-D stated she received an email follow-up from RN-C that an incident had occurred with C1 and he had been hospitalized. RN-D stated the agency was notified by FM-E on 12/24/15, of the incident. RN-D stated FM-F had spoken with RN-C on 12/24/15. RN-D stated she reported the incident to the CEP on 12/29/15. RN-D stated RN-C thought LPN-B had already reported the incident so she did not report. An interview with the agency director was conducted on 2/3/16, at 10:04 a.m. The director stated the incident should have been reported on 12/24/15, by RN-C. The licensee's policy titled, Patient Abuse, Neglect or Exploitation - Adult implemented 5/13, indicated the following. Employees of Accurate Home Care must report abuse, neglect, or exploitation of patients where the employee knows or suspects that such abuse, neglect or exploitation had occurred. The incident is reported to the appropriate authorities as required by law. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 805		
02015	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not	02015		

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02015	Continued From page 8 reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to	02015		

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02015	Continued From page 9 the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report to the common entry point (CEP) as required by state law an allegation of maltreatment/neglect when nursing staff failed to initiate cardiopulmonary resuscitation 1 of 3 clients (C1) allegations reviewed. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety, but had the potential to have harmed a client's health or safety), and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed. C1 was diagnosed with quadriplegia and acute respiratory failure which required a tracheostomy (surgical opening into the windpipe) placement. C1 was ventilator dependent. An Incident Report dated 12/23/15, indicated licensed practical nurse (LPN)-B transferred C1 to bed at 11:30 p.m. and connected C1 to the main ventilator with humidification. LPN-B turned C1 onto his side to remove the sling from	02015		

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02015	Continued From page 10	02015		

underneath the client. LPN-B heard a noise and the humidifier tipped on its side. LPN-B tried to empty the water trap to get rid of the excessive water. C1 asked LPN-B "bag him." LPN-B got the ambu bag (a pump device to assist ventilation) however, LPN-B did not bag C1 prior to going upstairs to get C1's family member (FM)-E. C1 was breathing at this time. When FM-E arrived downstairs C1 was unresponsive and not breathing so FM-E started to ventilate C1 with the ambu bag while LPN-B checked for a pulse. LPN-B was unable to find a pulse and FM-E started chest compressions. FM-E went upstairs to get FM-F. LPN-B continued to ventilate with the ambu bag and do chest compressions. FM-F came downstairs and found the suction machine was not working properly so the filter was changed and FM-E suctioned C1. The primary ventilator was not working so FM-F switched C1 to the backup ventilator. FM-E called 911 while LPN-B ventilated with the ambu bag and did compressions. FM-F suctioned for secretions. The police arrived along with the ambulance about five minutes later. The automatic external defibrillator (AED) was applied and a pulse was found. C1 was transferred to the hospital.

An interview was conducted with LPN-B on 2/19/16, at 11:03 a.m. LPN-B stated she did not notify the agency when the incident occurred with C1. LPN-B stated FM-E notified the agency and the agency contacted LPN-B five days later.

An interview with registered nurse (RN)-D clinical manager was conducted on 2/2/16, at 3:00 p.m. RN-D stated she received an email follow-up from RN-C that an incident had occurred with C1 and he had been hospitalized. RN-D stated the agency was notified by FM-E on 12/24/15, of the incident. RN-D stated FM-F had spoken with

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02015	Continued From page 11 RN-C on 12/24/15. RN-D stated she reported the incident to the CEP on 12/29/15. RN-D stated RN-C thought LPN-B had already reported the incident so that was her reason for not reporting. An interview with the agency director was conducted on 2/3/16, at 10:04 a.m. The director stated the incident should have been reported on 12/24/15, by RN-C. The licensee's policy titled, Patient Abuse, Neglect or Exploitation - Adult implemented 5/13, indicated the following. Employees of Accurate Home Care must report abuse, neglect, or exploitation of patients where the employee knows or suspects that such abuse, neglect or exploitation had occurred. The incident is reported to the appropriate authorities as required by law. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
248129 (Y1)	A. Building B. Wing (Y2)	7/11/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURATE HOME CARE LLC	9000 QUANTRELLE AVE NE OTSEGO, MN 55330

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix G0168 Reg. # 484.30 LSC	Correction Completed 06/24/2016	ID Prefix G0170 Reg. # 484.30 LSC	Correction Completed 06/24/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
H21487	A. Building B. Wing	7/11/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURATE HOME CARE LLC	9000 QUANTRELLE AVE NE OTSEGO, MN 55330

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 06/24/2016	ID Prefix 00805 Reg. # 144A.479, Subd. 6(a) LSC	Correction Completed 06/24/2016	ID Prefix 02015 Reg. # 626.557, Subd. 3 LSC	Correction Completed 06/24/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: JV5212

STATE FORM: REVISIT REPORT (11/06)