DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL02852025M
Compliance #: HL02852026C

Date Concluded: March 22, 2021

Name, Address, and County of Licensee Investigated:
Home Health at North Ridge
5500 Boone Avenue North
New Hope, MN 55428
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
Erin Johnson-Crosby, RN Special Investigator

Finding: 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):
It is alleged: Facility nursing staff neglected a client by failing to assess and intervene when the client's health declined, which led to the client's significant weight loss and developing a pressure injury.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to address the client's health decline and to communicate the client's decline to the Certified Nurse Practitioner (CNP), which delayed the client receiving care and services to address the client's significant change in condition. The CNP only became aware of the client's significant change in condition after notification from an outside agency.

Two facility registered nurses (RNs) were identified as alleged perpetrators (APs) of the neglect; however, there was insufficient evidence the APs were individually responsible for the maltreatment.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. Interviews were also conducted with the client's family member, case worker, the local ombudsman, and the primary care provider (PCP). The investigator reviewed facility and hospital documentation.

Review of the client's diagnoses included neurocognitive disorder, dementia, depression, and anxiety. The client lived in memory care for approximately two years, and received daily assistance with medication management, personal hygiene, incontinence management and showering/bathing.

Review of the client's last nursing assessment identified the client required staff supervision with dressing, toileting, and personal hygiene. She was independent with eating and mobility.

Review of the client's progress notes identified the client's family members informed facility staff they were concerned about the client's health. A few days later, the client complained of pain and had very dark colored urine. The Certified Nurse Practitioner (CNP) wrote orders for facility staff to obtain a urinalysis and urine culture from the client. The urine specimen was collected, but the laboratory analysis noted contaminants in the urine requiring the urine specimen be recollected. There is no documentation in the client's record that another urine specimen was collected. There is no documentation in the client's record that facility staff communicated with the CNP regarding the contaminated urine specimen, the client's condition, or need for new orders.

Review of the CNP visit note identified the client's weight was down 15 pounds. The client said she was trying to lose weight. During this visit, the CNP ordered laboratory tests and a psychiatric evaluation to assess the client's cognition.

Three weeks after the CNP's first visit, the client had lost another 15 pounds. The client was not able to get up from her chair, had difficulty walking and declined to eat most meals. The client spent most of the day in bed and did not like to interact with others. The CNP suggested adjusting the client's depression medications, but the client's family declined due to the increased risk of falls with the medication change. The CNP ordered laboratory tests and a nutritionist assessment. The CNP wrote in her visit notes that if the client's laboratory tests were negative, the client's health decline was likely a combination of cognitive impairment and depression. There were no nursing assessments documented that addressed the client's change in condition with her 30-pound weight loss or her decline in function, mobility, and emotional health. There was no documentation facility staff communicated with the CNP regarding the client's change in condition or most recent laboratory results.

Approximately 10 days after the CNP's second visit, an outside agency providing services to the client notified the CNP of their concerns regarding the client's change in condition. After the outside agency notified her about the client's condition, the CNP returned to the facility to evaluate the client. The CNP recommended the client be hospitalized or referred to hospice (end-

of-life) services. There were no nursing assessments documented that addressed the client's change in condition with her 30-pound weight loss or her decline in function, mobility, and emotional health. There was no documentation facility staff communicated with the CNP regarding the client's change in condition.

The family requested the client be sent to the hospital where she was diagnosed with a pulmonary embolism, pneumonia, failure to thrive, urinary tract infection and a pressure injury to her buttocks. Hospital staff admitted the client to hospice; she was discharged to another facility where she died. The facility documentation did not include any information regarding the clients' pressure injury or functional decline. The facility documentation also did not include a change in condition assessment or any changes to the client's service plan.

When interviewed, unlicensed staff members could not recall the client having any skin issues of concern. Unlicensed staff said the client received a shower or bath weekly, instead of daily as indicated on her service plan. Unlicensed staff said if there was a skin concern, they would let the nurse know. The unlicensed staff also said they notified the nursing staff that the client was losing weight and not eating. The unlicensed staff said the client refused meals but was offered alternative choices. They stated they encouraged the client to eat in the dining room but, at times, she refused.

When interviewed, the licensed practical nurse (LPN) said physicians were not allowed in the building for a while due to COVID-19, and client visits were completed via telehealth. Clients were usually seen every three months. The LPN stated she was not aware of why the client was not evaluated by a provider for six months. The LPN said if a client change in condition is identified, the provider is contacted. The LPN did not recall that the client had an increased need for assistance with transfers or walking and did not remember why the client was hospitalized. The LPN was not aware the client had pressure injuries.

When interviewed, AP#1 said a nursing assessment should be completed if there is a change in a client's condition. AP#1 said she remembered when the client's family members talked to her about the client not being taken care of, and she told the client's family to discuss their concerns with the Executive Director and the Director of Nursing. AP#1 stated she was not aware of why the client was sent to the hospital and was not aware of any skin concerns.

When interviewed, AP#2 said she is not responsible for day-to-day nursing tasks and mostly handles the business side of things. AP#2 was unable to comment if the client should have received a change in condition assessment and said that would be left up to the floor nursing staff. AP#2 was not aware of the client's pressure injury or why the client was hospitalized.

When interviewed, the Executive Director (ED) said she did not remember why the client was hospitalized, but that it may have been because of her weight loss. The ED also confirmed change in condition assessment should be completed for a client's health decline. The ED also said she was not aware of the client's pressure injury.

When interviewed, the client's family member stated due to COVID-19, the client's family members were not allowed inside the facility to see the client for many weeks. Once the family was able to visit the client, the family member was concerned with client's weight loss and her condition. The family member said they told facility staff that the client did not look well and did not seem to be taken care of. The family member stated she attempted multiple times to contact the facility with these concerns, but no one ever called them back or followed-up on the family member's concerns.

When interviewed, the CNP said she was notified by an outside agency that the client's health had declined. The CNP said the outside agency told her she should come and see the client. The CNP said she was uncertain how long the client had been declining before the outside agency notified her. The CNP said after examining the client, she informed the family the client should be admitted to hospice or be hospitalized due to the client's health decline. The CNP said the client's decline was due to her neurocognitive disorder; however, the CNP also said she would expect to be notified by facility staff regarding a client's change in condition.

In conclusion, neglect against the facility 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:
(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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long-Term Care
County Attorney for Hennepin County
City Attorney for New Hope, MN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H02852	A. BUILDING: ____ B. WING ____	C 01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH AT NORTH RIDGE	**5500 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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 January 14, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL02852027M/#HL02852028C. no correction orders were issued and #HL02852025M/#HL02852026C correction order 0325 was issued.	0 000		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) 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; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of three clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On March 22, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with an incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC). Refer to the public maltreatment report for details.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE