Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL03628014M
Compliance #: HL03628015C

Date Concluded: November 15, 2021

Name, Address, and County of Licensee Investigated:
Home Care Solutions
3390 Annapolis Lane #A
Plymouth, MN 55447
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility responsibility

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: The alleged perpetrator (AP) neglected to provide adequate supervision to the client when the client eloped from his home.

Investigative Findings and Conclusion:
Neglect was substantiated. The agency was responsible for the maltreatment. The agency failed to implement appropriate safety measures and failed to provide training, to ensure the client's safety.

The investigation included interviews with agency staff members, including nursing staff, and unlicensed staff. In addition, the investigator spoke with a hospital staff and the client's guardian. The investigator reviewed the client's medical record, internal investigation, and agency policies.

The client began home care services eleven months prior to the incident due to diagnoses that included dementia. The client resided in his private residence and received services from the

home care provider that included 24-hour supervision, medication administration, bathing, dressing, cooking, meal set-up, toileting, laundry, and housekeeping.

According to the client's care plan the client received 24-hour supervision due to difficulty adhering to safety precautions, difficulty following directions, and disorientation. The client's care plan lacked direction on how to provide 24-hour supervision. The client's care plan lacked direction for safety checks or visual observations. The client's care plan did not indicate client could be left alone. The client was assessed as an elopement risk. The client previously eloped from his home. The care plan lacked interventions to prevent elopement. The client's care plan indicated the client had a door alarm on his front door.

According to the internal investigation, the client eloped from the home through the side door. The AP thought the client was in his studio or garden. The AP searched for the client for 30-40 minutes and then called 911. The police found the client prior to the AP's phone call a mile from his home. The internal investigation indicated the client had an alarm on his front door but not the side door.

During an interview, the client's guardian said the client received 24-hour supervision due to his dementia diagnosis. The guardian said the client's healthcare provider recommended 24-hour supervision after a prior incident where the client went missing. The guardian said the AP reported she thought the client went to his studio. The guardian said the client was gone for at least 30-40 minutes given the distance the client was found from his home. The guardian said the client sustained a broken nose during the incident.

During an interview, the AP said the home health aides are scheduled to care for the client in his home, a week at a time. The AP said she stayed in the client's home during her scheduled week and slept in a bedroom, located on a separate level from the client. The AP stated she was downstairs watching TV when the client went to his studio. The AP said she checked on the client 15 minutes later and could not find him. The AP said she called 911 and reported the client missing. The AP said 911 reported the client was found and brought to the hospital. The AP said the client eloped through a side door. The AP said the side door did not have an alarm. The AP said the client should be checked on every 15-20 minutes.

During an interview, the Director of Nursing (DON) said the client had dementia and received 24-hour care. The DON said the client's home had four exits but only the front door had an alarm that sounded when the door opened. The DON said the client often worked in his studio unsupervised. The DON said the AP reported the client left through a side door located off the client's studio. The DON said the side door did not have an alarm. The DON said the AP looked for the client for 30 minutes, then reported the client missing. The DON said the agency directed the AP to call 911. The DON said the client was found a mile from his home and was diagnosed with a broken nose at the hospital. The DON said the agency does not have a policy that defines client supervision. The DON said a nurse recently assessed the client as an elopement risk. The DON said the facility did not add safety interventions to the client's care

plan after the client's elopement risk increased. The DON said she is unaware if staff were trained on the client's increased elopement risk.

In conclusion, neglect was substantiated. The agency failed to implement appropriate safety measures and failed to provide training, to ensure the client's safety.

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, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The agency educated staff members.

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.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care
Scott County Attorney
Shakopee City Attorney
Shakopee Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H03628	A. BUILDING: _____ B. WING _____	C 10/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME CARE SOLUTIONS	3390 ANNAPOLIS LANE SUITE A PLYMOUTH, MN 55447

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order pursuant to a survey. 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: On October 11, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL03628015C/#HL03628014M. At the time of the survey, there were 14 clients receiving services under the comprehensive license. The following correction orders are issued for #HL03628015C/#HL03628014M, tag identification 0325, 0810, and 1150.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
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:	0 325		

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0 325	Continued From page 1 (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 agency failed to ensure one of one client reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On November 15, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the agency was responsible for the maltreatment, in connection with an incident which occurred at C1's home. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
0 810 SS=G	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific	0 810		

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0 810	Continued From page 2 measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan, (IAPP) with safety interventions for one of one client (C1) reviewed after the client's elopement risk increased. This practice resulted in a level three 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included dementia and depression. C1's service plan dated, July 29, 2020, indicated C1 required assistance with bathing, meals, medication and behavior management. C1 required 24-hour supervision. Review of the licensee's Elopement Risk Assessment dated April 24, 2020, indicated C1's elopement risk score increased from an eight to a ten. The Elopement Risk Assessment indicated, "if the total score is 10 or greater, the client should be considered a risk for elopement. Prevention protocols should be followed and documented on the care plan."	0 810		

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0 810	Continued From page 3 C1's care plan was updated April 29, 2021, with increased elopement risk but no new elopement risk reduction interventions were added to the client's care plan. C1's Vulnerability Assessment/ Abuse Prevention Plan last updated April 29, 2021, was not updated with C1's increased elopement risk. The Vulnerability Assessment/ Abuse Prevention Plan failed to included interventions to prevent elopement. Review of the licensee's internal investigation documents indicated on June 19, 2021, at approximately 11:30 a.m. C1 eloped from the home through the side door. The internal investigation indicated the client had an alarm on his front door but not the side door nor other exits of the home. During an interview on October 12, 2021, at 10:00 a.m., C1's guardian (G)-A said C1 received 24-hour supervision due to his dementia diagnosis. G-A said C1's healthcare provider recommended 24-hour supervision after a prior incident where C1 went missing. G-A said ULP-C reported she thought C1 went to his studio. G-A said the C1 was gone for at least 30-40 minutes given the distance he was found from his home. G-A said C1 sustained a broken nose during the incident. G-A said C1 installed the alarm on the front door when the house was built. C1 said the alarm was not implemented by the licensee as an elopement intervention but was used as an intervention as it was already in place. C1's guardian said the front door was the only exit with an alarm. During an interview on October 21, 2021, at 10:35	0 810		

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0 810	Continued From page 4 a.m., director of nursing (DON)-B said the licensee did not add any elopement risk reduction interventions to the care plan after C1 was assessed as an increased elopement risk. DON-B said she was unaware if staff were trained on C1's increased elopement risk status. The licensee policy titled "Vulnerable Adult Protection," updated November 1, 2017, indicated "if vulnerability is identified HCS will create or revise the Vulnerability Care Plan to address the issue(s) identified to resolve the issue(s)." TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
01150 SS=G	144A.4795, Subd. 7(c) Training/Competency Evals Comp Staff (c) In addition to paragraph (b), training and competency evaluation for unlicensed personnel providing comprehensive home care services must include: (1) observation, reporting, and documenting of client status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the client; (4) recognizing physical, emotional, cognitive, and developmental needs of the client; (5) safe transfer techniques and ambulation;	01150		

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01150	Continued From page 5 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required for one of one unlicensed personnel (ULP)-C with employee records reviewed. This practice resulted in a level three 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included dementia and depression. C1's service plan dated, July 29, 2020, indicated C1 required assistance with bathing, meals, medication and behavior management. C1 required 24-hour supervision. Review of the licensee's Elopement Risk Assessment dated April 24, 2020, indicated C1 was assessed at a high risk for elopement. C1's care plan last updated April 29, 2021, indicated C1 required 24-hour supervision. C1's care plan identified 24-hour supervision as the	01150		

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01150	Continued From page 6 safety intervention for three separate vulnerability areas. ULP-C was hired on March 10, 2021. ULP-C's record lacked evidence of training and competency evaluations on how to provide 24-hours supervision. Review of the licensee's internal investigation documents indicated on June 19, 2021, at approximately 11:30 a.m. C1 eloped from the home. ULP-C thought C1 was in the studio or garden but had eloped from the home through a side door. During an interview on October 12, 2021, at 10:00 a.m., C1's guardian (G)-A said C1 received 24-hour supervision due to his dementia diagnosis. G-A said C1's healthcare provider recommended 24-hour supervision after a prior incident where C1 went missing. G-A said ULP-C reported she thought C1 went to his studio. G-A said the C1 was gone for at least 30-40 minutes given the distance he was found from his home. G-A said C1 sustained a broken nose during the incident. During an interview on October 14, 2021, at 12:55 p.m., the ULP-C said she provided direct care to the client. ULP-C said the client received 24-hour care and required visual observation every 15-20 minutes. ULP-C said she hadn't seen C1 for 15-20 minutes and when she checked on him, she couldn't find him. ULP-C said C1 was very independent and didn't need to be checked on every 10 minutes. During an interview on October 21, 2021, at 10:35 a.m., director of nursing (DON)-B said she trained staff on how to provide C1's care. DON-B said	01150		

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01150	Continued From page 7 staff must know where C1 is at all times. DON-B said there was no required time between visual observations. DON-B said the licensee does not have a policy on client supervision or how to provide 24-hour supervision. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01150		