Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL20566007M
Compliance #: HL20566008C

Date Concluded: September 8, 2021

Name, Address, and County of Licensee Investigated:
Madonna Meadows of Rochester
3035 Salem Meadows Drive SW
Rochester, MN 55902
Olmsted County

Facility Type: Home Care Provider

Evaluator's Name: Zalei Lewis, RN
Special Investigator
Revised by: Benjamin Hanson
Revised Date: February 10, 2022

Finding: <u>Not Substantiated</u>

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:
It is alleged: The facility neglected the client when staff failed to provide adequate care to prevent skin breakdown and pressure wounds.

Investigative Findings and Conclusion:

<u>Upon reconsideration, the findings of this report were changed to not substantiated.</u>

~~Neglect was substantiated. The facility was responsible for the maltreatment.~~ The facility failed to ensure skin assessments, documentation, and interventions were provided to the client. The client had significant skin breakdown that was left untreated. The facility also neglected to address the pain associated with the skin breakdown. The facility failed to develop interventions to address the client's refusal of medication and cares. The facility failed to document and report changes in client condition to the client's health care provider.

The investigation included interviews with facility staff, including nursing and unlicensed staff. The investigation also included observation of client cares by unlicensed staff, dining room service observation, and client interviews. Client records, facility policies, facility grievances, facility incident reports, and employee records were reviewed.

The client's diagnoses included cancer, congestive heart failure, dermatitis seborrheic, and acute kidney failure. The facility record indicated the client had a rash and other nonspecific skin eruption, and impetigo, unspecified. Review of the client's service plan indicated the client received services that included assistance with activities of daily living, housekeeping, medication management, toileting, and assist of one for transfers.

Review of the client's record indicated the client's service plan, care plan, and assessments did not include specific treatments, interventions, or documentation of the client's current skin issues. Nursing progress notes indicated that the client refused medication and cares; interventions were not developed to address the client's refusals.

During review, hospital records indicated the client was admitted to hospice with multiple pressure injuries (bilateral ears, coccyx) and areas of skin irritation. The record also indicated that the client had not been bathed for a long time. The note stated that upon arrival the nurses found that patient had signs of neglect. The client's hair and skin were described as greasy/crusty/yellow.

The investigator reviewed photos of the client's skin. The skin on the client's face and scalp was deep pink, crusty, flaky, raw, and appeared inflamed.

During interview, family members stated they had concerns about care at the facility. The family were unable to visit the client for many months due to COVID-19 precautions. When family was allowed to see the client, the client's face was very red and inflamed. The client reported to the family that the skin condition was painful, and that she did not want to go on living. The family was told by staff that it was just dry skin. The family member also stated that it required a large amount of time just brushing her hair to remove the dead skin.

During interview, one of the client's primary care providers was interviewed and stated she was not aware of prior skin conditions. She also stated that she thought the client's skin reaction was due to the client's cancer medication (Ibrutinib).

During interview, a facility nurse stated that the medication Ibrutinib was discontinued prior to late January 2021. The nurse acknowledged that the client was not on the medication at the time of the reaction. The nurse stated that she was aware of one pressure injury on the client's ear and asked the patient's provider for tubing cushions.

During an interview with a representative of the drug manufacturer it was stated, that there are no cases reported of a skin reaction like the client's caused by Ibrutinib.

The investigator requested additional policies, the client's medication administration record and treatment record, complete staff contact information, additional care documentation, additional nursing notes, and the communication book. Multiple attempts were made via email and phone to request this information. The facility did not respond to these requests.

~~In conclusion, neglect was substantiated. There is a preponderance of evidence the facility failed to ensure the client's skin issues were assessed, and as a result, necessary interventions were not offered or attempted.~~ **Upon reconsideration, the findings of this report were changed to not 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, patient is deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A.

Action taken by facility:
None.

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. 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.

Cc: The Office of Ombudsman for Long-Term Care
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20566	A. BUILDING: _____ B. WING _____	C 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ******REVISED****** Upon reconsideration, changes have been made. The 0325 and 0645 tags were removed. Tag 0865 was reduced from a G to a D. ******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(s) pursuant to an investigation. 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 June 29-30, 2021, the Minnesota Department of Health initiated an investigation of complaint HL20566007M, HL20566008C. The following correction order is issued for HL20566007M, HL20566008C, tag identification 0865.	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 investigators ' 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 licensing order follow-ups. 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).	
0 865 SS=D	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions	0 865		

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0 865	Continued From page 1 Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed update the service plan and follow the service plan as written for one of one clients reviewed. The facility failed to provide skin interventions as provided in the service plan, and the facility failed to update the service plan when the client's provider issued an order for weight monitoring, or to follow the existing service for	0 865		

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0 865	Continued From page 2 weight monitoring. As a result, the client experienced significant deterioration in skin condition, and a significant weight loss. This practice resulted in a level two 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, but was not likely to cause 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: A site visit to the facility was conducted on June 29, 2021, and June 30, 2021. The client's diagnoses included Waldenstrom macroglobulinemia, congestive heart failure, and acute kidney failure. The facility diagnoses also include rash and other nonspecific skin eruption, and impetigo, unspecified. Outside medical records from the client's medical provider do not include these skin specific diagnoses. The client was receiving services including assistance with activities of daily living, housekeeping, bathing, medication management, toileting, twice weekly and up to assist of one for transfers. The service plan for the client provided has no date on the plan itself, but has an "evaluation date" of February 24, 2021. The Resident evaluations for the client are dated February 18, 2021, and February, 25, 2021. The later evaluation form stating "Readmission to	0 865		

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0 865	Continued From page 3 (facility) following hospitalization 2-21-21-2-24-21." The service plan contains "category/resident needs: behavior/depression/anxiety (select what applies.) "needs occasional intervention, responses to cues (1-2 times a month.)" The "services/assistance provisions" states, "Resident is anxious and intermittent redirecting is needed. Often refuses showers." No interventions were contained in the chart to address shower refusal. Anxiety is not listed as a client diagnosis. The service plan contains "category/resident needs: skin integrity: does the client have any history of the following? rash, pale, bruises, open sores, itching, moist, cellulitis, pressure ulcers, cool, flushed, wounds, other. The "services/assistance provisions" states, "has documented history of skin concerns, dermatitis seborrheic." Directly following this the service plan contains "category/resident needs: wound care-daily dressing changes, wound measuring, application of ointment/creams." The "services/assistance provisions" states, "1. Apply Vanicream to forehead BID twice daily. 2. Apply A&D ointment to other parts of face after washing. 3. Check daily, change every 3 days, 8 AM. Apply foam border dressing to cover wound L. buttock, change daily and as needed if soiled. **Reposition**" An outside facility record note, dated May 11, 2021, states, "Patient admitted to unit this afternoon on Hospice Service. Upon arrival, RN and Charge RN found that patient has physical signs of abuse and neglect. Patient has multiple pressure injuries (bilateral ears, coccyx) and areas of skin irritation. It also appeared that patient had not been bathed for a long time. Hair	0 865		

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0 865	Continued From page 4 and skin greasy/crusty/yellow... RN and Charge RN gave patient a bed bath and obtained photos of pressure injuries." An outside facility wound care nurse note, dated May 12, 2021, states, "#1 Pressure injury stage 2 ear right Assessment: Patient with stage 2 pressure injury of top right ear that measures 0.2 cm x 0.2 cm with red wound bed and no exudate noted. Wound edges are defined, intact, and even with wound bed. Periwound is intact with dry, yellow, flakes on skin and throughout hair. Area is painful with touch. #2 Deep tissue pressure injury (DTPI) ear left Assessment: Patient with DTPI on top of left ear that measures 0.2 cm x 0.2 cm, closed and purple. Wound edges are indistinct with periwound of intact, dry, yellow flaking skin throughout. Ear wounds appear to be related to a nasal cannula, but patient is not currently wearing a NC, nor can I find a note stating that patient requires NC with oxygen. #3 Friction injury buttocks Assessment: Patient turned to left side independently, but required assist of 1 to maintain position on side. Patient with friction injury to bilateral buttocks with blanchable erythema present throughout and an open ulceration on right buttock that measures 0.5 cm x 0.5 cm. Wound bed is pink/yellow with no exudate noted. Wound edges are defined and intact with small amount of peeled skin surrounding. Periwound with blanchable erythema throughout." Wound treatment plans and Medication Administration Record were requested on July 15, 2021, and July 20, 2021 but never provided. LPN-E was interviewed on July 27, 2021, when asked where documentation of changes in the wounds or skin would be found she stated, "I	0 865		

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0 865	Continued From page 5 would have to check back in the communication book. That is where they would document anything like that. Off of the top of my head I don't remember any instances of that I look at the communication book every day. I don't remember any instances of notes about, I guess I would have to look at it I guess I can't say for sure." The service plan for the client states "weigh daily prior to breakfast." The nurse evaluation dated February 18, 2021 states, "The RN will observe or review the treatment or therapy plan during the client monitoring visit and as needed. Her current treatments or therapies are compression stocking application, weekly weights, skin creams, and monitoring." The nurse evaluation dated February 25, 2021 does not address weight, nor does it contain treatment and therapy section. The physician order dated April 16, 2021, states, "Obtain and record weight prior to breakfast. If possible, do not wake her and allow her to sleep. Nurse to notify provider for weights <102 or >115 lbs. Once a day on Monday, Wednesday, Friday; 0800 AM." During the month of May, the CareAssist documentation provided has two documented weights charted for the client on May 3, 2021, of 98.8 pounds, and on May 7,2021, of 99.2 pounds. There are no refusals of weighing charted. An outside facility record note from the client's	0 865		

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0 865	Continued From page 6 May 11, 2021 stay includes a diagnosis of "loss weight abnormal." LPN-E was interviewed on July 27, 2021, and asked which weighing practice was being observed for the client as it's different in different places, and she stated, "I don't know anything about the service plan or evaluation because that would be a change of condition. I just put orders in the system matrix and the staff would chart on it." When asked if the weights were ever conveyed to the provider in May, and if it's documented, she states, "I don't see it." During an interview with FM-C on July 21, 2021, the family member stated, "we would have conversations with nursing but there weren't any care meetings that I'm aware of." When asked if there were changes in the service plan, or if FM-C had a copy of the service plan she stated, "I don't remember if I was signing something that needed to be renewed. I know there was paperwork that they put on my mom's table to sign." On July 21, 2021, an interview with a county staff person involved with the client's care at the time that the allegation was made stated "The daughter was frustrated with what she believes is some oversight on the part of (facility) staff for the past six months. They have noticed that (the client's) eye and skincare have not been followed as ordered by her PCP and is stated in her care plan." When asked if the staff member had any concerns about the client's care, the staff member stated, "I left a message for (a staff member) and didn't hear back from her until I called back and (the staff member) had said that there was a care conference for (the client) the previous day. So nobody, nobody, cued me into	0 865		

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0 865	Continued From page 7 that so I wasn't even a part of that care conference." On July 23, 2021, FM-G was interviewed and states, "I have pictures, and I am talking the worst case of cradle cap...face was covered in red, raw, pussy sores and dry skin. Her phone was kept literally caked with gunk it took me 10 minutes to scrub off because she had that stuff on her face, it had been weeping. I mean it was caked in so you know I brought wipes and I, that was the first thing I did every time I went. The table at her side of where she sits in her chair was, had spills that hadn't been wiped out, and there were jars and some quarters that had been there like stuck...It took me a month to get the hand soap dispenser in the bathroom fixed. I kept reporting it, because I used it all of the time." On July 21, 2021 FM-C states, "They were not providing the care that she needed. Her face was very red, inflamed, painful, and they would say that it's just dry skin. I would try to convey that it's not just dry skin, it doesn't just need lotion. So I don't think that the staff had really paid attention to what her needs were, and that she suffered as a consequence." The family member also stated, "my mom had such terrible skin issues that my sister would spent, I couldn't even tell you how, how many, how long she'd be just trying to brush through my mom's hair, trying to remove some of the dead skin and even it was behind my mom's ears and on her neck and they're just not paying attention. And, you know, it had gotten to such an extreme point that, you know to hear my mom it's like I (the client) just can't go on like this." An outside facility record notes dated May 11, 2021 states, "She (the client) was admitted 5/11/2021 for respite care due to lack of caregiver	0 865		

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0 865	Continued From page 8 support in her assisted living facility." Time Period for Correction: Seven Days	0 865		