DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21030046M
Compliance #: HL21030047C

Date Concluded: January 12, 2021

Name, Address, and County of Licensee Investigated:
Spectrum Community Health, Inc
6205 Crossman Lane
Inver Grove Heights, MN 55076
Dakota County

Name, Address, and County of Housing with Services location:
Carefree Living
1225 Division Street East
St. Cloud, MN 56304
Benton County

Facility Type: Home Care Provider

Investigator's Name: Jeri Gilb, RN, MSN, CNP
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):
The alleged perpetrator(s), neglected the client when they failed to provide monitoring and follow up of the client after a significant change of condition.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for maltreatment. The facility neglected the client when multiple staff failed to provide monitoring, follow through, communication, and ongoing assessment when the client had a significant condition change. The client was not checked on by staff for approximately 6 hours and was found deceased in her room.

An equal opportunity employer.

The investigation included interviews with facility staff, including nursing staff, and unlicensed staff. The investigation included review of the client medical record, facility policy and procedures, staff training, and employee record review.

The client's diagnoses included diabetes mellitus 2, chronic obstructive pulmonary disease (COPD), and hypertension. The client's medical record indicated the client received assistance with medication management and administration, bathing assist, meal preparation, and safety checks once a shift.

The client's medical record indicated the client developed symptoms of nausea and vomiting after a known exposure to COVID-19 in the workplace. The client missed work and received a COVID-19 test.

The next day, the client's medical record indicated staff checked the client oxygen level and got a reading of 77%. There was no follow up documentation the facility staff rechecked or followed up on the client's low oxygen reading. The client also complained of a severe headache and eye pain, and was requesting pain medication approximately every two to six hours. The client's new, ongoing pain was not reported to the on-call nurse. The client requested pain medication from staff for (unspecified) pain of a 9 out of 10. The client was not checked on by staff for approximately 6 hours and was found deceased in her room.

During interview, the facility on-call nurse stated staff called and reported the clients oxygen saturations were 77%. The nurse directed staff to recheck the client's oxygen level and monitor the client throughout the night, however, this was not documented anywhere in the clients medical record. The nurse stated staff did not notify her of the client's significant change of condition including the severe headache or eye pain.

When interviewed, the facility staff stated the evening and overnight hours when the client experienced a significant change of condition they were short staffed. The three staff members caring for the client during this time all stated they did not recheck the client's oxygen saturation after the reading of 77%.

The client's medical record indicated no staff went in to the client's room to monitor her pain for five hours or her oxygen level for nine hours.

The next morning the oncoming staff found the client deceased in her room.

In conclusion, neglect was substantiated. Multiple staff at the facility were aware of the client's significant change of condition and did not follow up or monitor the client.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator(s) interviewed: Yes

Action taken by facility: Alleged perpetrator 1 is no longer employed by the facility. Alleged perpetrator 2 received retraining 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.

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

cc:
The Office of Ombudsman for Long-Term Care
Benton County Attorney
St. Cloud City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21030	A. BUILDING: ______ B. WING ______	C 01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY HEALTH INC	6205 CROSSMAN LANE INVER GROVE HEIGHTS, MN 55076

(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(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 December 4, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL21030046M/ HL21030047C. At the time of the investigation, there were #38 clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL21030046M/ HL21030047C; 0265 and 0325.	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).	
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who	0 265		

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0 265	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure services were provided according to accepted medical or nursing standards for one of one client, client 1 (C1), reviewed with a significant change of condition. C1 had a significant change of condition including a low oxygen level, complaints of new, significant, ongoing pain, and was weak. The client was not checked on for approximately six hours and was found deceased in her room. 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 indicated diagnoses including diabetes mellitus type 2 (DM2), chronic obstructive pulmonary disease (COPD), and	0 265		

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hypertension.

C1's service plan dated April 1, 2020 included safety checks three times a day, medication administration, glucose checks, and hygiene assistance. C1 received insulin injections three times daily and at bedtime as needed.

C1's progress notes dated September 17, 2020 indicated C1 was not working that day due to vomiting. C1's temperature documented on the vitals sheet at 8:54 a.m. was 97.9 degrees Fahrenheit.

C1's progress notes dated September 18, 2020 at 1:48 p.m. indicated C1 was tested for COVID-19 due to vomiting. Staff were to encourage C1 to drink fluids and notify the provider of any additional symptoms.

C1's medication administration record (MAR) indicated C1 received acetaminophen 650 mg at 7:41 p.m. on September 18, 2020 for eye pain rated 7 out of 10. ULP-A indicated on the MAR the acetaminophen was not effective in relieving C1's pain. ULP-C administered 650 mg acetaminophen at 12:18 a.m. on September 19, 2020 for pain rated 9 out of 10. There was no documentation regarding the pain location, and ULP-C indicated the acetaminophen was not effective in relieving the client's pain.

C1's treatment record dated September 19, 2020, indicated C1 had a scheduled blood sugar check to be completed at 3:00 a.m. ULP-C documented the 3:00 a.m. blood sugar check was not completed and wrote, "refused."

C1's next progress note dated September 19, 2020 at 8:25 a.m., approximately 6 hours since

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C1 had been checked on by staff, indicated C1 was found deceased and cold in her apartment. No resuscitation was attempted due to C1 being "gone for some time".

C1's progress note [late entry] by registered nurse (RN)-E dated September 21, 2020 at 10:10 a.m. from September 18, 2020 at 9:15 p.m. indicated unlicensed personnel (ULP)-A called at 8:44 p.m. on September 18, 2020 to report C1's oxygen level was 75%. RN-E directed ULP-A to warm C1's fingers and check the client's oxygen level with a different oximeter and call RN-E back with any further concerns. RN-E indicated she received no further calls regarding C1's oxygen saturation or regarding any change of condition for C1.

The facility investigation undated, indicated on September 19, 2020, ULP-G entered C1's room and found the client deceased. ULP-G contacted 911 and RN-E. The investigation indicated related to the incident, ULP-C received a written warning and was retrained on observation, reporting and documenting clients change in conditions, the home care bill of rights, when to call the nurse/emergency procedures, orientation to clients including review or service check off list, care plan, documentation required by unlicensed staff, pulse oximetry, reporting parameters for vital signs and weight; and EMAR system and documentation.
The investigation included a interview with ULP-C dated September 21, 2020, indicated she arrived to work at 10:00 p.m., on September 18, to work the overnight shift. ULP-B reported C1 was experiencing stomach flu symptoms, had been tested for COVID-19, and was on isolation precautions until the test results were known. ULP-C stated C1 requested Tylenol for pain on

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0 265	Continued From page 4 September 18, at approximately 10:30 p.m. ULP-C told C1 it was too early for the next dose of pain medication but she would return when the next dose could be given. ULP-C stated C1 was sitting in her bed and she assisted the client to lay back down in bed. On September 19th, at 1:30 a.m. ULP-C returned to C1's room and administered Tylenol. C1 indicated her pain was an 8 or a 9 on a 1-10 scale. ULP-C stated C1 struggled to take the tylenol but was able to get it down with some tap water. At approximately 2:00-2:15 a.m. on September 19, C1 put on her call light. ULP-C stated C1 requested assistance to get out of bed and move into the chair. ULP-C stated C1 appeared to stumble and the client had a "difficult" time with the transfer. ULP-C stated she asked C1 if she wanted her to call the physician and C1 replied, "No." Prior to leaving C1's room, ULP-C mentioned to the client she had a 3:00 a.m. blood sugar check due shortly. C1 did not reply and ULP-C left C1's room. ULP-C did not return to C1's room to complete C1's 3:00 a.m. scheduled blood sugar check. The facility investigation interview completed on September 22, 2020, with ULP-B, indicated on September 18, 2020, ULP-A reported to her C1's oxygen level was 75% at 7:40 p.m. ULP-A stated she attempted to have C1 warm her hands up and she would recheck it again. ULP-B stated ULP-A told her to recheck C1's oxygen saturation but ULP-B stated she forgot to check C1's oxygen saturation prior to leaving her shift. C1's last oxygen saturation reading was done on September 18th, at 7:40 p.m. which was completed by ULP-A with a reading of 75%. The facility investigation interview completed on September 22, 2020, with ULP-A indicated, she reported to ULP-B to recheck C1's oxygen saturations. ULP-A stated the last oxygen saturation reading she completed on C1 was on	0 265		

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September 18, 2020, at 7:40 p.m. when the clients oxygen saturation reading was 75%.

During interview on December 29, 2020 at 2:02 p.m., ULP-A stated at about 7:30 p.m. on September 18, 2020, C1's oxygen level was in the mid to low 70's. The room was cold, so she told C1 to warm her hands. C1 did not appear short of breath, but did complain of having a headache and being tired. ULP-A stated she called RN-E at around 8:30 p.m. to report C1's low oxygen level of 75%, and thought she mentioned this level was from an hour earlier, and she also told RN-E about C1's request for Acetaminophen for the new complaints of eye pain. ULP-A stated she did not recheck C1's oxygen level after getting a reading of 75%. ULP-A stated her shift ended early that evening related to budgeting and prior to leaving the facility that evening, she told another staff member, ULP-B, to warm C1's hands, check her oxygen saturation again with a different oximeter, and call RN-E back if the clients oxygen saturation was not above 90%. ULP-A stated on a normal night, she would have ideally returned to C1's room in 20 minutes to recheck her oxygen level but the facility was short staffed and her shift was ending early.

During an interview on December 23, 2020 at 10:28 a.m., RN-E stated ULP-A called her at approximately 8:45 p.m. September 18, 2020, to report C1 had an oxygen level of 75%. ULP-A told RN-E the room was cold and C1's finger could be cold. RN-E stated ULP-A was in the room with C1 and she could hear C1 talking and answering questions, so knew C1 was alert. ULP-A denied C1 was short of breath or had any other issues. RN-E stated she directed ULP-A to have C1 take deep breaths, raise the head of the

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bed, warm C1's hands, and check her oxygen level with a different oximeter. She told ULP-A to call her back if the clients oxygen level was not above 90%. RN-E stated she told ULP-A to do checks on C1 throughout the night. RN-E did not recall how frequently she advised checks to be completed for C1, and stated she did not document this direction in C1's medical record. RN-E stated she thought C1's oxygen saturation level of 75% occurred at 8:45 p.m. when ULP-A called her. RN-E was not told of C1's new, significant complaints of eye pain and received no further calls regarding C1 until the next morning, September 19, 2020 when C1 was found deceased in her recliner. RN-E stated the facility does not have oxygen on hand for as needed use for clients experiencing acute, low oxygen levels.

During interview on December 28, 2020 at 5:00 p.m., ULP-B stated on the evening shift of September 18, 2020, at around 8:30 p.m., ULP-B took over care for C1 when ULP-A ended her shift early. ULP-B stated ULP-A told her C1 needed to have her oxygen level checked again with a different oximeter due to a prior low oxygen reading. ULP-B stated she forgot to recheck C1 as the facility was short-staffed and she was providing cares for clients on two floors. ULP-B did not see C1 prior to ending her shift at approximately 10:00 p.m. on September 18, 2020. She gave report to the oncoming staff, ULP-C. However, ULP-B could not remember if she passed on C1's prior low oxygen reading, the need for rechecking the client, and/or the new eye pain C1 reported.

During interview on December 23, 2020 at 11:37 a.m., ULP-C stated when she began her shift September 18, 2020 at approximately 10:00 p.m., ULP-B reported staff were to "suit up" when

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0 265	Continued From page 7 working with C1 due to COVID-19 symptoms and the pending test results. However, ULP-C stated nothing was passed on regarding C1's low oxygen level, the need to follow up on obtaining an oxygen saturation, C1's change in condition, or complaints of pain. ULP-C stated C1 used her call pendant more that night complaining of being hot and cold. C1 requested pain medication for a headache at approximately 11:00 p.m., but it was too soon since the last dose and C1 could not have any medication until after midnight. ULP-C administered Acetaminophen 650 mg September 19, 2020 at 12:18 a.m. ULP-C stated C1 did not seem short of breath at that time. At approximately 2:30 a.m., C1 pressed her call light and asked for more pain medication because of head pain. ULP-C told C1 it was too early for her to have more pain medication. ULP-C assisted C1 to her recliner per C1's request. ULP-C stated C1 was weak and "stumbly", which was new for C1 as she could normally walk independently. C1 was due for a blood sugar check at 3:00 a.m. ULP-C stated she asked C1 if she wanted her to come back and do the glucose check at 3:00 a.m. and C1 did not reply. ULP-C stated C1 did not utilize her call light again so she thought the client was resting and she did not go back and complete C1's 3:00 a.m. glucose check. ULP-C stated the last time she observed C1 was at 2:30 a.m. on September 19, 2020, prior to ending her shift at 6:15 a.m. The facility policy titled Documentation of Medication Services policy, dated November 7, 2017, indicated staff should administer PRN (as needed) medications exactly as prescribed and document administration of PRN medications in the client's MAR. Documentation will include the PRN medication name, symptoms or indication, dose, route, time, and effectiveness. Staff will	0 265		

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0 265	Continued From page 8 determine the effectiveness of the PRN medication by asking the client or checking nonverbal symptoms that prompted the administration of the PRN medication. Staff will document on the MAR in a timely manner, whether or not the medication was effective, providing any additional details that apply. The facility policy titled On-Call Policy, dated October 11, 2017 indicated the facility registered nurse should be contacted with any client change in condition, i.e. change in mobility, orientation or behavior, vomiting, diarrhea, slurred speech, change in skin color or tone, unusual swelling or edema, unusual shortness of breath or coughing, decreased eating or drinking, or any change from the client's "normal" level of functioning. In addition, the registered nurse should be contacted if the client is experiencing pain that is new and pain that is not relieved with PRN medication. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 265		
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;	0 325		

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0 325	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 developed significant changes in condition. C1 died in the facility. Findings include: On December 23, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) is required. Please refer to the public maltreatment report for details.	