DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Minnesota Heritage House	HL21049048	January 19, 2018
Facility Address:	**Time of Visit:**	**Date Concluded:**
920 Southeast Fourth Street	8:15 a.m. to 5:30 p.m.	March 9, 2018
Facility City:	**Investigator's Name and Title:**	
Little Falls	Rhylee Gilb, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56345	Morrison

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when the alleged perpetrator failed to provide an adequate medical assessment when the client had a change in condition resulting in the client's death.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect is substantiated. The alleged perpetrator (AP) failed to assess a significant change in condition when the client had persistent diarrhea and a decline in physical abilities. Even when informed of changes in oxygen saturation and blood pressure, the AP did not assess the client, implement new interventions, contact the client's nurse practitioner, or send the client to an emergency room for another day. The client had a bowel infection, Clostridium Difficile (C-Diff), that progressed to sepsis (total body infection), and the client died as a result.

The client received services from a provider licensed as a comprehensive home care provider. The client was admitted with diagnoses that included schizophrenia and asthma. The client's service plan indicated s/he required assistance with bathing and medication administration. The client was independent with ambulation with a walker, dressing, grooming, eating, and toileting. In addition, the client was continent of bowel and urine. The client's life support decision indicated s/he wanted full cardiopulmonary resuscitation and to be treated with antibiotics.

C-Diff is common in older adults after antibiotic use. Symptoms of C-Diff typically occur within five to ten days after starting an antibiotic but may occur after the first day or up to two months later. Some symptoms include three or more watery stools a day (lasting more than two days), nausea, loss of appetite and

dehydration.

The client was seen by his/her nurse practitioner and was ordered an antibiotic to treat a possible foot infection.

Approximately six weeks after completing the antibiotic, the client began to have symptoms of C-Diff. On a Wednesday, the client sought out a home health aide (HHA) to report "all off the babies" s/he had the night before. The HHA stated with the client's mental health, the client often made odd statements and whenever s/he referred to "babies," the client usually indicated stomach issues. The HHA stated the client's toilet was full of diarrhea bowel movement, it smelt awful, and looked like C-Diff. The HHA stated s/he recalled the client was on an antibiotic previously and reported the symptoms and diarrhea to the AP.

The next day, Thursday, the client spoke with a family member and reported s/he had been having diarrhea for several days. The client was seen during a routine psychiatry visit that day as well. The psychiatry nurse practitioner dictated the client talked about "having babies in his/her bathroom." The nurse practitioner made no changes to the client's medications, until the client's primary provider could rule out a urinary tract infection. The day shift HHA stated the client was normally present for all meals and activities, however Thursday morning the client was not at breakfast. About 8:00 a.m., the HHA checked on the client and the client reported s/he still had bad diarrhea and his/her stomach hurt. The HHA again reported the symptoms to the AP. Throughout the day, the client continued to have significant amounts of diarrhea, and after each episode the HHA reported to the AP. By the end of his/her shift, the HHA stated the AP just told him/her "I understand" in response to the reports about the client. The HHA stated s/he did not see the AP go into the client's room, and the HHA did not receive any direction on changes to the client's care. Another staff member also noticed the client did not leave his/her room that day and stated it was unusual. The staff member reported it to the AP, who replied, that s/he knew because the other HHA "has told me ten times already today." The evening shift HHA also stated the client did not come to dinner. At 8:00 p.m., the evening shift HHA stated the client had a trail of diarrhea to his/her bathroom. It took three staff to assist with cleaning the client and getting him/her to bed because the client was not responding normally. The HHA stated the diarrhea had a strong odor, was very loose, and was yellowish in color. The client's vital signs were otherwise normal. The HHA called the AP with the client's status and inability to wake up. The AP instructed the HHA to take the client's vital signs every 15 minutes, and stated as long as the client's vitals are fine, then the client would be fine.

On Friday, the same HHA that worked with the client both on Wednesday and Thursday, reported for day shift and found the client in worse condition than the previous days. The HHA felt the AP was doing nothing for the client and got into a dispute with the AP regarding this. The HHA was removed from the client's unit and sent to work on a different unit for the day. The replacement HHA stated the client continued to have diarrhea with a strong odor. Previously, the client had been able to take him/herself to the bathroom, but now the client needed assistance with walking. The HHA reported the client's symptoms to the licensed practical nurse (LPN) and the AP. Friday evening, the evening shift HHA stated the client continued to have foul-smelling diarrhea. The client's blood pressure also decreased from 138/72 to 100/69. The HHA stated s/he called the AP, who was the nurse on-call, and reported the client's symptoms, blood pressure, and that s/he thought the client had C-Diff. The AP replied "s/he probably does" and gave no further instructions to

care for the client.

On Saturday, the client continued with diarrhea throughout the day shift. By evening shift, the client had become completely incoherent and his/her blood pressure dropped to 88/50. The client's oxygen saturation was also low, at 82% on room air. The same evening shift HHA from Friday called the AP, who was again the nurse on-call, to report the client's status. The HHA asked to send the client to the hospital, but the AP refused and instructed the AP to administer oxygen to the client and write a progress note on the client's status. The HHA administered the oxygen at two liters per minute and the client's oxygen saturation increased to 87% after 15 minutes.

By Sunday, the client had at least four known days of continuous diarrhea and three days of no oral intake per HHA staff. On Sunday morning, the LPN observed the client and noted the client still had low oxygen, low blood pressure, and was lethargic. The LPN called the AP who then instructed the LPN to send the client to the hospital. The client was transported at 8:17 a.m.

At the hospital, the client was diagnosed with septic shock (total body infection) and renal failure. The client was intubated (for artificial breathing), and given antibiotics and intravenous fluids. The client's condition worsened, and the client was transferred to a secondary hospital on Monday. At the secondary hospital, the client underwent exploratory surgery which confirmed the sepsis was related to C-Diff, and the client had a removal of his/her colon. Despite these efforts, the client died on Tuesday. The client's death record indicated the cause of death was related to C-Diff and septic shock.

The client's record lacked any progress notes dictated by an RN, or any change in condition assessment completed by an RN.

During an interview, the nurse practitioner stated s/he had not received any notification from the home care provider about a change in the client's condition until the client was sent to the hospital. The nurse practitioner stated the client had chronic kidney disease, chronic obstructive pulmonary disease, and chronic artery disease. The effect of C-Diff definitely would have stressed the client's body.

During an interview with the client's family member, the family member stated the home care provider never mentioned anything about the possibility of the client having C-Diff and the family member never noticed infection precautions in the facility.

During an interview with the AP, the AP stated s/he did not receive a phone call about the client's status until Saturday night and stated s/he knew nothing more.

The home care provider did not complete an investigation into the incident or the HHA's complaints regarding the AP's lack of intervention with the client

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

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 alleged perpetrator (AP) is responsible for the neglect, because although the the AP had completed recent training on C-Diff protocols, was a registered nurse, and was on-call during the incident, the AP failed to take any action in response to the client's changing condition.

The facility is also responsible for the neglect because the facility failed to ensure appropriate assessment and interventions for the client's change in condition.

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:

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

(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

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

This home care provider is now closed.

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
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Physician Progress Notes

- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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: The client is deceased

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, 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: Client is deceased

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: None

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Twelve

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:

☒ Dignity/Privacy Issues

☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A

Were photographs taken: ◯ Yes ◉ No Specify: NA

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

Minnesota Board of Medical Practice

The Office of Ombudsman for Long-Term Care

Crow Wing County Attorney

Crow Wing County Medical Examiner

Pequot Lakes Police Department

Pequot Lakes City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21049	A. BUILDING: _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

(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, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 19, 2018, a complaint investigation was initiated to investigate complaint #HL21049048. The following violations were identified; however, the home care provider had closed, therefore no time period for correction is specified and no follow-up will be completed.	0 000		
0 265 SS=J	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services;	0 265		

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0 265	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement contact precautions when a client had a contagious infection for 1 of 3 clients (C1) reviewed. C1 had persistent diarrhea and died from a bowel infection, clostridium difficile (C-Diff). C2 and a home health aide contracted the infection after C1's death. This practice resulted in a level four violation (a violation that results in 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). The findings include: The Mayo Clinic website indicates C-Diff is common in older adults after antibiotic use. Symptoms of C-Diff typically occur within five to ten days after starting an antibiotic but may occur after the first day or up to two months later. Some symptoms include three or more watery stools a day (lasting more than two days), nausea, loss of appetite and dehydration. Spores from C. difficile bacteria are passed in feces and spread to food, surfaces, and objects when people who are infected do not wash their hands thoroughly. These spores can persist in a room for weeks or months. Preventative measures include hand-washing using soap and warm water, contact precautions including for staff and visitors to wear disposable gloves and isolation gowns, and thorough cleaning with products that contain bleach.	0 265		

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0 265	Continued From page 2 C1's medical record was reviewed. C1 was admitted with diagnoses that included schizophrenia and asthma. C1's undated service plan indicated C1 was independent with ambulation with a walker, dressing, grooming, eating and toileting. C1 was continent. C1 required assistance with bathing and medication administration. C1's life support decision dated January 31, 2017 indicated she did want full cardiopulmonary resuscitation and to be treated with antibiotics. C1's last registered nurse (RN) assessment was completed August 21, 2017. C1's physician orders were reviewed. On September 21, 2017, nurse practitioner (NP)-N ordered an antibiotic, Clindamycin 300 milligrams three times a day for seven days for a possible foot infection (cellulitis). During an interview on February 6, 2018 at 9:07 a.m., home health aide (HHA)-H stated on Wednesday, November 8, 2017, she worked with C1. C1 showed HHA-H her bathroom and C1 stated you will not believe all of the babies I had last night. HHA-H explained with C1's mental health, C1's reference to have 'having babies' usually indicated stomach issues. HHA-H stated she observed C1's toilet was full of diarrhea bowel movement. HHA-H stated the diarrhea smelt awful and looked like C-Diff. She knew C1 was on an antibiotic and verbally reported the symptoms and diarrhea to RN-C. During an interview on February 6, 2018 at 2:07 p.m., family member (FM)-O stated C1's sister reported she spoke with C1 on Thursday, November 9, 2017. C1 reported she had diarrhea for several days. During an interview on February 6, 2018 at 9:07	0 265		

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0 265	Continued From page 3 a.m., HHA-H stated normally C1 is at breakfast table waiting when she arrives to work at 7:00 a.m. Thursday, November 9, 2017 C1 was not in the dining room for breakfast. By 8:00 a.m., when C1 still had not come out of her room, HHA-H went to check on C1 and C1 stated she had still been having really bad diarrhea and her stomach hurt. HHA-H stated she reported right away to RN-C. Throughout the day, C1 had massive amounts of diarrhea and after each episode HHA-H reported it to RN-C. HHA-H stated C1's vital signs were normal and she did not have a fever. HHA-H stated RN-C replied "I understand" after hearing HHA-H's concerns, but HHA-H stated she believed nothing was being done. HHA-H never observed RN-C go into C1's room. RN-C did not give HHA-H further direction to care for C1. During an interview on January 31, 2017 at 4:15 p.m., HHA-I stated she worked with C1 on Thursday November 9, 2017 during the evening shift. C1 refused to come out for supper. At 8:00 p.m., HHA-I went to give C1 her medications and found C1 had a trail of diarrhea from her recliner to her bathroom. It took three total staff to assist C1 with cleaning her up and getting her back to bed because she was not responding and staff could not get her to wake up. The diarrhea had a strong odor, and was very loose and yellowish in color. HHA-I stated she took C1 was vitals, which were normal, and called RN-C. RN-C told her to take C1's vitals every 15 minutes and as long as C1's vitals are fine, then C1 will be fine. During an interview on January 24, 2018 at 3:45 p.m., HHA-J stated she worked with C1 on Friday, November 10, 2017 during the day shift. C1 had been skipping meals which was uncommon for her. She was also complaining of	0 265		

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0 265	Continued From page 4	0 265		

more leg pain, diarrhea, and sleeping more often. C1's diarrhea had a very strong odor. HHA-J reported C1's symptoms to both the licensed practical nurse (LPN)-F and RN-C. C1 would say things that were out of the ordinary, so HHA-J stated she felt like the nurses did not look into it.

During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated she worked with C1 on Friday, November 10, 2017 during the evening shift. C1 continued to have diarrhea and back pain. C1's diarrhea had a strong odor. HHA-G stated she had called RN-C, who was on-call that evening, and reported C1's symptoms. HHA-J told RN-C she thought C1 had C-Diff and RN-C replied, she probably does. HHA-G stated she looked for gowns, but could not find any and the licensee did not provide any gowns.

During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on Saturday, November 11, 2017, C1 was totally incoherent and her blood pressure was low. HHA-G called RN-C, who was on-call, and asked the nurse to come in or allow her to send C1 to the hospital. HHA-G stated RN-C told her she could not send C1 to the hospital because C1 made up stories. HHA-G stated C1 was schizophrenic and made outlandish comments, but this sickness was not made up. C1 had previously gotten around fine and now required three staff to assist in cleaning her up. C1 previously always attended meals and had not stopped eating, was not able to walk anymore, and was completely delusional.

C1's progress note dated November 12, 2017 (Sunday), LPN-E indicated C1 had low oxygen saturation, low blood pressure, and was lethargic. LPN-E contacted RN-C who advised C1 to be sent to the hospital. C1 was transported at 8:17

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0 265	Continued From page 5 a..m. C1's hospital records were reviewed. On November 12, 2017, C1 was diagnosed with septic shock (total body infection) and renal failure. C1 was intubated (started artificial breathing), and given antibiotics and intravenous fluids. C1's condition worsened and was transferred to a secondary hospital on November 13, 2017. At the secondary hospital, C1 underwent exploratory surgery, confirmed sepsis was related to C-Diff and had a removal of her colon. Despite life saving efforts, C1 died on November 14, 2017. C1's death record indicated cause of death was related to C-Diff and septic shock. During an interview on January 31, 2018 at 2:55 p.m., HHA-K stated no contact precautions were put in place while C1 had diarrhea and there were no gowns. HHA-K stated after C1 was hospitalized, the nurses would not confirm or deny if C1 had C-Diff and still did not provide gowns for staff to clean her room. During an interview on February 6, 2018 at 2:07 p.m., FM-O stated the licensee never mentioned anything about C1 having C-Diff when he stopped at the licensee to gather C1's items for her hospital stay. FM-O, also after C1 had passed away and they removed the items from her room, FM-O stated he still was not sure if the licensee had disinfected her room. During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated about three or four days after C1 passed away, she also experienced C-Diff and was out of work for approximately four days. HHA-H stated the facility never provided gowns to	0 265		

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0 265	Continued From page 6 clean C1's room and was directly cleaning up feces and contaminated items. Progress notes for another client, C2, were reviewed. On November 17, 2017 staff requested and received an order to start hospice services. On November 19, 2017, hospice intake was completed and ordered a stool sample to check for C-Diff. On November 20, 2017, the stool sample was collected and sent to lab. On November 21, 2017, the lab test came back positive for C-Diff and C2 was started on an antibiotic. C2 died on November 22, 2017. C2's death record indicated causes of death was Alzheimer's disease, diverticulitis (within a month), and C-Diff (within a week).	0 265		
0 325 SS=J	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; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure freedom from maltreatment (neglect) for 1 of 3 clients (C1) reviewed when the licensee failed to assess a significant change in condition. C1 had persistent diarrhea and died from a bowel infection, clostridium difficile (C-Diff). This practice resulted in a level four violation (a violation that results in serious injury, impairment,	0 325		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

(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 7 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). The findings include: The Mayo Clinic website indicates C-Diff is common in older adults after antibiotic use. Symptoms of C-Diff typically occur within five to ten days after starting an antibiotic but may occur after the first day or up to two months later. Some symptoms include three or more watery stools a day (lasting more than two days), nausea, loss of appetite and dehydration. Spores from C. difficile bacteria are passed in feces and spread to food, surfaces, and objects when people who are infected do not wash their hands thoroughly. These spores can persist in a room for weeks or months. Preventative measures include hand-washing using soap and warm water, contact precautions including for staff and visitors to wear disposable gloves and isolation gowns, and thorough cleaning with products that contain bleach. C1's medical record was reviewed. C1 was admitted with diagnoses that included schizophrenia and asthma. C1's undated service plan indicated C1 was independent with ambulation with a walker, dressing, grooming, eating and toileting. C1 was continent. C1 required assistance with bathing and medication administration. C1's life support decision dated January 31, 2017 indicated she did want full cardiopulmonary resuscitation and to be treated with antibiotics. C1's last registered nurse (RN) assessment was completed August 21, 2017.	0 325		

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0 325	Continued From page 8 C1's physician orders were reviewed. On September 21, 2017, nurse practitioner (NP)-N ordered an antibiotic, Clindamycin 300 milligrams three times a day for seven days for a possible foot infection (cellulitis). During an interview on February 6, 2018 at 9:07 a.m., home health aide (HHA)-H stated on Wednesday, November 8, 2017, she worked with C1. C1 showed HHA-H her bathroom and C1 stated you will not believe all of the babies I had last night. HHA-H explained with C1's mental health, C1's reference to have 'having babies' usually indicated stomach issues. HHA-H stated she observed C1's toilet was full of diarrhea bowel movement. HHA-H stated the diarrhea smelt awful and looked like C-Diff. She knew C1 was on an antibiotic and verbally reported the symptoms and diarrhea to RN-C. During an interview on February 6, 2018 at 2:07 p.m., family member (FM)-O stated C1's sister reported she spoke with C1 on Thursday, November 9, 2017. C1 reported she had diarrhea for several days. C1's psychiatry visit, dated November 9, 2017, indicated NP-S evaluated C1 and found her condition had worsened. NP-S dictated C1 talked about having babies in her bathroom and staff threw snakes in her bed. NP-S indicated no medication changes would be made until C1's primary provider was able to rule out a urinary tract infection. During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated normally C1 is at breakfast table waiting when she arrives to work at 7:00 a.m. Thursday, November 9, 2017 C1 was not in the dining room for breakfast. By 8:00 a.m., when	0 325		

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0 325	Continued From page 9 C1 still had not come out of her room, HHA-H went to check on C1 and C1 stated she had still been having really bad diarrhea and her stomach hurt. HHA-H stated she reported right away to RN-C. Throughout the day, C1 had massive amounts of diarrhea and after each episode HHA-H reported it to RN-C. HHA-H stated C1's vital signs were normal and she did not have a fever. HHA-H stated RN-C replied "I understand" after hearing HHA-H's concerns, but HHA-H stated she believed nothing was being done. HHA-H never observed RN-C go into C1's room. RN-C did not give HHA-H further direction to care for C1. During an interview on January 19, 2018 at 4:45 p.m., with an anonymous staff (AS)-D, AS-D stated she had observed C1 not attending meals and indicated that was unusual. AS-D reported to RN-C and stated RN-C replied, yes I know, HHA-H had told me ten times already today. The HHA 24 hour board shift report sheets were reviewed. On November 9, 2017, during the evening shift it was dictated C1 acted like she could not walk and wanted a wheelchair. During an interview on January 31, 2017 at 4:15 p.m., HHA-I stated she worked with C1 on Thursday November 9, 2017 during the evening shift. C1 refused to come out for supper. At 8:00 p.m., HHA-I went to give C1 her medications and found C1 had a trail of diarrhea from her recliner to her bathroom. It took three total staff to assist C1 with cleaning her up and getting her back to bed because she was not responding and staff could not get her to wake up. The diarrhea had a strong odor, and was very loose and yellowish in color. HHA-I stated she took C1 was vitals, which were normal, and called RN-C. RN-C told her to	0 325		

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0 325	Continued From page 10 take C1's vitals every 15 minutes and as long as C1's vitals are fine, then C1 will be fine. The HHA 24 hour board shift report sheet dated November 10, 2017 indicated on day shift C1 continued to have loose stools all shift. During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated she was scheduled to work with C1 on Friday 11/10/17 during the day shift. When she arrived on duty, C1 was in worse shape. She felt RN-C was not doing anything for C1 and they got into a dispute about it. HHA-H was moved off of C1's unit and sent to work a different unit for the day. During an interview on January 24, 2018 at 3:45 p.m., HHA-J stated she worked with C1 on Friday, November 10, 2017 during the day shift. C1 had been skipping meals which was uncommon for her. She was also complaining of more leg pain, diarrhea, and sleeping more often. C1's diarrhea had a very strong odor. HHA-J reported C1's symptoms to both the licensed practical nurse (LPN)-F and RN-C. C1 would say things that were out of the ordinary, so HHA-J stated she felt like the nurses did not look into it. The HHA 24 hour board shift report dated November 10, 2017 during the evening shift indicated C1 continued to have loose stools and had blood pressure readings of 138/72 and 100/69. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated she worked with C1 on Friday, November 10, 2017 during the evening shift. C1 continued to have diarrhea and back pain. C1's diarrhea was foul. HHA-G stated she had called RN-C, who was on-call that evening	0 325		

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0 325	Continued From page 11 and reported C1's symptoms. HHA-J told RN-C she thought C1 had C-Diff and RN-C replied, she probably does. The HHA 24 hour board shift report dated November 11, 2017 during the day shift indicated C1 continued to have loose stools. The evening shift indicated C1 had strong gurgling noises was put on oxygen and must monitor. C1's blood pressure was 88/50. C1's progress notes were reviewed. On Saturday, November 11, 2017 on the evening shift, HHA-G documented C1 had wheezing and her oxygen saturation was 82% on room air. C1 was placed on oxygen at two liters per minute and after 15 minutes, C1's oxygen saturation increased to 87%, During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on Saturday, November 11, 2017, C1 was totally incoherent and her blood pressure was low. HHA-G called RN-C, who was on-call, and asked the nurse to come in or allow her to send C1 to the hospital. HHA-G stated RN-C told her she could not send C1 to the hospital because C1 made up stories. HHA-G stated C1 was schizophrenic and made outlandish comments, but this sickness was not made up. C1 had previously gotten around fine and now required three staff to assist in cleaning her up. C1 previously always attended meals and had not stopped eating, was not able to walk anymore, and was completely delusional. C1's progress note dated November 12, 2017 (Sunday), LPN-E indicated C1 had low oxygen saturation, low blood pressure, and was lethargic. LPN-E contacted RN-C, who directed C1 to be sent to the hospital. C1 was transported at 8:17	0 325		

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0 325	Continued From page 12 a..m. C1's progress notes dated November 5 through 14, 2017 lacked any progress notes by an RN. C1's record lacked a change in condition RN assessment. C1's hospital records were reviewed. On November 12, 2017, C1 was diagnosed with septic shock (total body infection) and renal failure. C1 was intubated (started artificial breathing), and given antibiotics and intravenous fluids. C1's condition worsened and was transferred to a secondary hospital on November 13, 2017. At the secondary hospital, C1 underwent exploratory surgery, confirmed sepsis was related to C-Diff and had a removal of her colon. Despite life saving efforts, C1 died on November 14, 2017. C1's death record indicated cause of death was related to C-Diff and septic shock. During an interview on February 5, 2018 at 3:03 p.m:, NP-N stated she had not received any notification from the licensee about a change in C1's condition until C1 was hospitalized on November 12, 2017. NP-N stated during her last visit with C1 on October 24, 2017, C1 was still her usual self and ambulated independently. C1 had chronic kidney disease, chronic obstructive pulmonary disease, and chronic artery disease. NP-N stated the effect of C-Diff definitely would have stressed C1's body. The undated, licensee policy titled Algorithms for Prevention and Management of Clostridium Difficile Infections in Long Term Care Facilities, indicated if a client experiences new onset	0 325		

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0 325	Continued From page 13 diarrhea and has three or more unformed stools in less than a 24 hour period, the client's provider should be contacted and have a C-Diff lab sample ordered.	0 325		
0 645 SS=G	144A.475, Subd. 1 Conditions Subdivision 1. Conditions. (a) The commissioner may refuse to grant a temporary license, renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider: (1) is in violation of, or during the term of the license has violated, any of the requirements in sections144A.471 to 144A.482; (2) permits, aids, or abets the commission of any illegal act in the provision of home care; (3) performs any act detrimental to the health, safety, and welfare of a client; (4) obtains the license by fraud or misrepresentation; (5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the home care	0 645		

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0 645	Continued From page 14 provider's clients; (8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department; (9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter; (10) refuses to initiate a background study under section 144.057 or 245A.04; (11) fails to timely pay any fines assessed by the department; (12) violates any local, city, or township ordinance relating to home care services; (13) has repeated incidents of personnel performing services beyond their competency level; or (14) has operated beyond the scope of the home care provider's license level. (b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider. This MN Requirement is not met as evidenced by: Based on interview and document review, the home care provider failed to cooperate with the	0 645		

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0 645	Continued From page 15 investigation and destroyed records regarding their compliance, when the home care provider retaliated against an employee who was believed to have filed a vulnerable adult report and deleted a relevant progress note which had been requested by the state agency. 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). The findings include: During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated shortly after C1 passed away, she had received text messages from RN-C harassing and accusing her for submitting a vulnerable adult report to Minnesota Adult Abuse Reporting Center for RN-C's actions with C1. HHA-H stated RN-C and HM-A removed her off her full time schedule for two weeks, and she was placed in the float position, which resulted in a loss of work hours and pay. HHA-H stated she showed the text messages and voiced her concerns about RN-C to HM-A, and was eventually allowed her to return to her regular work schedule. During an interview on January 19, 2018 at 4:45 p.m., anonymous staff (AS)-D stated on December 8, 2017, HHA-G reported registered nurse (RN)-C made her delete an progress note entry she had made on C1 on November 11, 2017. AS-D stated she had received a phone call	0 645		

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0 645	Continued From page 16 from the State Department of Health inquiring about C1 and transferred the phone call to RN-C. AS-D saw on RN-C's desk faxed paperwork on C1, including the progress notes and observed, the entry made by HHA-G was not included. During an interview on January 22, 2018 at 3:35 p.m., AS-B stated HHA-G reported RN-C made her delete her progress note. AS-B went into the electronic system and verified the note was deleted and reviewed the deleted note. AS-B stated RN-C reported she had to give further system access to HHA-G in order for the note to be deleted. AS-B stated she informed HM-A, and HM-A stated she was aware the note was deleted. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on December 8, 2017, the coroner called regarding C1, and RN-C told her she needed to remove her note. HHA-G stated RN-C reprimanded her for making the note, stated she was not allowed to make nurse notes, and was in violation of the licensee policy. HHA-G stated RN-C gave her administrative access to remove the note. HHA-G stated she knew it was wrong to remove a note from a medical record and reported it. During an interview on January 19, 2017 at 5:00 p.m., HM-A stated she was aware of the deleted note. RN-C disciplined HHA-G because she wrote a note and was not a nurse. When inquired why HHA-G was disciplined and note the other three HHAs, HM-A stated because HHA-G applied oxygen without a doctors order and was not supposed to provide a treatment. During an interview on February 6, 2018 at 9:47 a.m., RN-C stated applying oxygen is a part of the	0 645		

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0 645	Continued From page 17 licensee standing orders and she taught all HHA's house to use an E-tank (oxygen) during the oxygen class. During an on-site visit on January 19, 2018, the deleted note was recovered from the electronic medical record. The note was verified that it was entered on November 11, 2017 by HHA-G. The note read: "Resident found in room tonight at about 9:30 with a strong wheezing gurgling sound from what appears to be her throat, listen to lungs and didn't appear to noise from them. Her temp was at 95.1 O2/82 P/96 R/15 BP/85/50. Put resident on oxygen at 2 liters residents O2 went up to 87 within 15 minutes. Monitoring BP and O2." (O2 = oxygen saturation, P = pulse, R = respirations and BP = blood pressure). The note was verified have be been deleted on December 8, 2017 and it was verified the State Department of Health did contact the licensee for information regarding C1. The licensee electronic medical record, electronically signed entries by the logged in user, there for, titles of staff were listed behind the name of the staff member making an entry. An HHA could not have dictated a note as nurse. C1's progress notes for November 2017 had three HHA staff make an entry aside from HHA-G.	0 645		
0 860 SS=J	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the	0 860		

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0 860	Continued From page 18 services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to assess a significant change in condition for 1 of 3 clients (C1) reviewed. C1 had persistent diarrhea and died from a bowel infection, clostridium difficile (C-Diff). This practice resulted in a level four violation (a violation that results in 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). The findings include:	0 860		

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0 860	Continued From page 19 The Mayo Clinic website indicates C-Diff is common in older adults after antibiotic use. Symptoms of C-Diff typically occur within five to ten days after starting an antibiotic but may occur after the first day or up to two months later. Some symptoms include three or more watery stools a day (lasting more than two days), nausea, loss of appetite and dehydration. Spores from C. difficile bacteria are passed in feces and spread to food, surfaces, and objects when people who are infected do not wash their hands thoroughly. These spores can persist in a room for weeks or months. Preventative measures include hand-washing using soap and warm water, contact precautions including for staff and visitors to wear disposable gloves and isolation gowns, and thorough cleaning with products that contain bleach. C1's medical record was reviewed. C1 was admitted with diagnoses that included schizophrenia and asthma. C1's undated service plan indicated C1 was independent with ambulation with a walker, dressing, grooming, eating and toileting. C1 was continent. C1 required assistance with bathing and medication administration. C1's life support decision dated January 31, 2017 indicated she did want full cardiopulmonary resuscitation and to be treated with antibiotics. C1's last registered nurse (RN) assessment was completed August 21, 2017. C1's physician orders were reviewed. On September 21, 2017, nurse practitioner (NP)-N ordered an antibiotic, Clindamycin 300 milligrams three times a day for seven days for a possible foot infection (cellulitis). During an interview on February 6, 2018 at 9:07 a.m., home health aide (HHA)-H stated on	0 860		

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0 860	Continued From page 20 Wednesday, November 8, 2017, she worked with C1. C1 showed HHA-H her bathroom and C1 stated you will not believe all of the babies I had last night. HHA-H explained with C1's mental health, C1's reference to have 'having babies' usually indicated stomach issues. HHA-H stated she observed C1's toilet was full of diarrhea bowel movement. HHA-H stated the diarrhea smelt awful and looked like C-Diff. She knew C1 was on an antibiotic and verbally reported the symptoms and diarrhea to RN-C. During an interview on February 6, 2018 at 2:07 p.m., family member (FM)-O stated C1's sister reported she spoke with C1 on Thursday, November 9, 2017. C1 reported she had diarrhea for several days. C1's psychiatry visit, dated November 9, 2017, indicated NP-S evaluated C1 and found her condition had worsened. NP-S dictated C1 talked about having babies in her bathroom and staff threw snakes in her bed. NP-S indicated no medication changes would be made until C1's primary provider was able to rule out a urinary tract infection. During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated normally C1 is at breakfast table waiting when she arrives to work at 7:00 a.m. Thursday, November 9, 2017 C1 was not in the dining room for breakfast. By 8:00 a.m., when C1 still had not come out of her room, HHA-H went to check on C1 and C1 stated she had still been having really bad diarrhea and her stomach hurt. HHA-H stated she reported right away to RN-C. Throughout the day, C1 had massive amounts of diarrhea and after each episode HHA-H reported it to RN-C. HHA-H stated C1's vital signs were normal and she did not have a	0 860		

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0 860	Continued From page 21 fever. HHA-H stated RN-C replied "I understand" after hearing HHA-H's concerns, but HHA-H stated she believed nothing was being done. HHA-H never observed RN-C go into C1's room. RN-C did not give HHA-H further direction to care for C1. During an interview on January 19, 2018 at 4:45 p.m., with an anonymous staff (AS)-D, AS-D stated she had observed C1 not attending meals and indicated that was unusual. AS-D reported to RN-C and stated RN-C replied, yes I know, HHA-H had told me ten times already today. The HHA 24 hour board shift report sheets were reviewed. On November 9, 2017, during the evening shift it was dictated C1 acted like she could not walk and wanted a wheelchair. During an interview on January 31, 2017 at 4:15 p.m., HHA-I stated she worked with C1 on Thursday November 9, 2017 during the evening shift. C1 refused to come out for supper. At 8:00 p.m., HHA-I went to give C1 her medications and found C1 had a trail of diarrhea from her recliner to her bathroom. It took three total staff to assist C1 with cleaning her up and getting her back to bed because she was not responding and staff could not get her to wake up. The diarrhea had a strong odor, and was very loose and yellowish in color. HHA-I stated she took C1 was vitals, which were normal, and called RN-C. RN-C told her to take C1's vitals every 15 minutes and as long as C1's vitals are fine, then C1 will be fine. The HHA 24 hour board shift report sheet dated November 10, 2017 indicated on day shift C1 continued to have loose stools all shift. During an interview on February 6, 2018 at 9:07	0 860		

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0 860	Continued From page 22 a.m., HHA-H stated she was scheduled to work with C1 on Friday 11/10/17 during the day shift. When she arrived on duty, C1 was in worse shape. She felt RN-C was not doing anything for C1 and they got into a dispute about it. HHA-H was moved off of C1's unit and sent to work a different unit for the day. During an interview on January 24, 2018 at 3:45 p.m., HHA-J stated she worked with C1 on Friday, November 10, 2017 during the day shift. C1 had been skipping meals which was uncommon for her. She was also complaining of more leg pain, diarrhea, and sleeping more often. C1's diarrhea had a very strong odor. HHA-J reported C1's symptoms to both the licensed practical nurse (LPN)-F and RN-C. C1 would say things that were out of the ordinary, so HHA-J stated she felt like the nurses did not look into it. The HHA 24 hour board shift report dated November 10, 2017 during the evening shift indicated C1 continued to have loose stools and had blood pressure readings of 138/72 and 100/69. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated she worked with C1 on Friday, November 10, 2017 during the evening shift. C1 continued to have diarrhea and back pain. C1's diarrhea was foul. HHA-G stated she had called RN-C, who was on-call that evening and reported C1's symptoms. HHA-J told RN-C she thought C1 had C-Diff and RN-C replied, she probably does. The HHA 24 hour board shift report dated November 11, 2017 during the day shift indicated C1 continued to have loose stools. The evening shift indicated C1 had strong gurgling noises was	0 860		

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0 860	Continued From page 23 put on oxygen and must monitor. C1's blood pressure was 88/50. C1's progress notes were reviewed. On Saturday, November 11, 2017 on the evening shift, HHA-G documented C1 had wheezing and her oxygen saturation was 82% on room air. C1 was placed on oxygen at two liters per minute and after 15 minutes, C1's oxygen saturation increased to 87%, During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on Saturday, November 11, 2017, C1 was totally incoherent and her blood pressure was low. HHA-G called RN-C, who was on-call, and asked the nurse to come in or allow her to send C1 to the hospital. HHA-G stated RN-C told her she could not send C1 to the hospital because C1 made up stories. HHA-G stated C1 was schizophrenic and made outlandish comments, but this sickness was not made up. C1 had previously gotten around fine and now required three staff to assist in cleaning her up. C1 previously always attended meals and had not stopped eating, was not able to walk anymore, and was completely delusional. C1's progress note dated November 12, 2017 (Sunday), LPN-E indicated C1 had low oxygen saturation, low blood pressure, and was lethargic. LPN-E contacted RN-C, who directed C1 to be sent to the hospital. C1 was transported at 8:17 a..m. C1's progress notes dated November 5 through 14, 2017 lacked any progress notes by an RN. C1's record lacked a change in condition RN assessment.	0 860		

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0 860	Continued From page 24 C1's hospital records were reviewed. On November 12, 2017, C1 was diagnosed with septic shock (total body infection) and renal failure. C1 was intubated (started artificial breathing), and given antibiotics and intravenous fluids. C1's condition worsened and was transferred to a secondary hospital on November 13, 2017. At the secondary hospital, C1 underwent exploratory surgery, confirmed sepsis was related to C-Diff and had a removal of her colon. Despite life saving efforts, C1 died on November 14, 2017. C1's death record indicated cause of death was related to C-Diff and septic shock. During an interview on February 5, 2018 at 3:03 p.m., NP-N stated she had not received any notification from the licensee about a change in C1's condition until C1 was hospitalized on November 12, 2017. NP-N stated during her last visit with C1 on October 24, 2017, C1 was still her usual self and ambulated independently. C1 had chronic kidney disease, chronic obstructive pulmonary disease, and chronic artery disease. NP-N stated the effect of C-Diff definitely would have stressed C1's body. The undated, licensee policy titled Algorithms for Prevention and Management of Clostridium Difficile Infections in Long Term Care Facilities, indicated if a client experiences new onset diarrhea and has three or more unformed stools in less than a 24 hour period, the client's provider should be contacted and have a C-Diff lab sample ordered.	0 860		
0 880 SS=J	144A.4791, Subd. 11 Client Complaint and Investigative Process	0 880		

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0 880	Continued From page 25 Subd. 11. Client complaint and investigative process. (a) The home care provider must have a written policy and system for receiving, investigating, reporting, and attempting to resolve complaints from its clients or clients' representatives. The policy should clearly identify the process by which clients may file a complaint or concern about home care services and an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints. A home care provider must have a process in place to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights. This complaint system must provide reasonable accommodations for any special needs of the client or client's representative if requested. (b) The home care provider must document the complaint, name of the client, investigation, and resolution of each complaint filed. The home care provider must maintain a record of all activities regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review.	0 880		

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0 880	Continued From page 26 (c) The required complaint system must provide for written notice to each client or client's representative that includes: (1) the client's right to complain to the home care provider about the services received; (2) the name or title of the person or persons with the home care provider to contact with complaints; (3) the method of submitting a complaint to the home care provider; and (4) a statement that the provider is prohibited against retaliation according to paragraph (d). (d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to investigate staff complaints and concerns of a registered nurse (RN) actions with suspected maltreatment (neglect) of vulnerable adults for 2 of 3 clients (C1, C3) reviewed. In addition, staff experienced retaliation for their complaints. This practice resulted in a level four violation (a violation that results in 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). The findings include:	0 880		

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0 880	Continued From page 27 The Mayo Clinic website indicates C-Diff is common in older adults after antibiotic use. Symptoms of C-Diff typically occur within five to ten days after starting an antibiotic but may occur after the first day or up to two months later. Some symptoms include three or more watery stools a day (lasting more than two days), nausea, loss of appetite and dehydration. Spores from C. difficile bacteria are passed in feces and spread to food, surfaces, and objects when people who are infected do not wash their hands thoroughly. These spores can persist in a room for weeks or months. Preventative measures include hand-washing using soap and warm water, contact precautions including for staff and visitors to wear disposable gloves and isolation gowns, and thorough cleaning with products that contain bleach. C1's medical record was reviewed. C1 was admitted with diagnoses that included schizophrenia and asthma. C1's undated service plan indicated C1 was independent with ambulation with a walker, dressing, grooming, eating and toileting. C1 was continent. C1 required assistance with bathing and medication administration. C1's life support decision dated January 31, 2017 indicated she did want full cardiopulmonary resuscitation and to be treated with antibiotics. C1's last registered nurse (RN) assessment was completed August 21, 2017. C1's physician orders were reviewed. On September 21, 2017, nurse practitioner (NP)-N ordered an antibiotic, Clindamycin 300 milligrams three times a day for seven days for a possible foot infection (cellulitis). During an interview on February 6, 2018 at 9:07 a.m., home health aide (HHA)-H stated on	0 880		

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0 880	Continued From page 28 Wednesday, November 8, 2017, she worked with C1. C1 showed HHA-H her bathroom and C1 stated you will not believe all of the babies I had last night. HHA-H explained with C1's mental health, C1's reference to have 'having babies' usually indicated stomach issues. HHA-H stated she observed C1's toilet was full of diarrhea bowel movement. HHA-H stated the diarrhea smelt awful and looked like C-Diff. She knew C1 was on an antibiotic and verbally reported the symptoms and diarrhea to RN-C. During an interview on February 6, 2018 at 2:07 p.m., family member (FM)-O stated C1's sister reported she spoke with C1 on Thursday, November 9, 2017. C1 reported she had diarrhea for several days. C1's psychiatry visit, dated November 9, 2017, indicated NP-S evaluated C1 and found her condition had worsened. NP-S dictated C1 talked about having babies in her bathroom and staff threw snakes in her bed. NP-S indicated no medication changes would be made until C1's primary provider was able to rule out a urinary tract infection. During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated normally C1 is at breakfast table waiting when she arrives to work at 7:00 a.m. Thursday, November 9, 2017 C1 was not in the dining room for breakfast. By 8:00 a.m., when C1 still had not come out of her room, HHA-H went to check on C1 and C1 stated she had still been having really bad diarrhea and her stomach hurt. HHA-H stated she reported right away to RN-C. Throughout the day, C1 had massive amounts of diarrhea and after each episode HHA-H reported it to RN-C. HHA-H stated C1's vital signs were normal and she did not have a	0 880		

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0 880	Continued From page 29 fever. HHA-H stated RN-C replied "I understand" after hearing HHA-H's concerns, but HHA-H stated she believed nothing was being done. HHA-H never observed RN-C go into C1's room. RN-C did not give HHA-H further direction to care for C1. During an interview on January 19, 2018 at 4:45 p.m., with an anonymous staff (AS)-D, AS-D stated she had observed C1 not attending meals and indicated that was unusual. AS-D reported to RN-C and stated RN-C replied, yes I know, HHA-H had told me ten times already today. The HHA 24 hour board shift report sheets were reviewed. On November 9, 2017, during the evening shift it was dictated C1 acted like she could not walk and wanted a wheelchair. During an interview on January 31, 2017 at 4:15 p.m., HHA-I stated she worked with C1 on Thursday November 9, 2017 during the evening shift. C1 refused to come out for supper. At 8:00 p.m., HHA-I went to give C1 her medications and found C1 had a trail of diarrhea from her recliner to her bathroom. It took three total staff to assist C1 with cleaning her up and getting her back to bed because she was not responding and staff could not get her to wake up. The diarrhea had a strong odor, and was very loose and yellowish in color. HHA-I stated she took C1 was vitals, which were normal, and called RN-C. RN-C told her to take C1's vitals every 15 minutes and as long as C1's vitals are fine, then C1 will be fine. The HHA 24 hour board shift report sheet dated November 10, 2017 indicated on day shift C1 continued to have loose stools all shift. During an interview on February 6, 2018 at 9:07	0 880		

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0 880	Continued From page 30 a.m., HHA-H stated she was scheduled to work with C1 on Friday 11/10/17 during the day shift. When she arrived on duty, C1 was in worse shape. She felt RN-C was not doing anything for C1 and they got into a dispute about it. HHA-H was moved off of C1's unit and sent to work a different unit for the day. During an interview on January 24, 2018 at 3:45 p.m., HHA-J stated she worked with C1 on Friday, November 10, 2017 during the day shift. C1 had been skipping meals which was uncommon for her. She was also complaining of more leg pain, diarrhea, and sleeping more often. C1's diarrhea had a very strong odor. HHA-J reported C1's symptoms to both the licensed practical nurse (LPN)-F and RN-C. C1 would say things that were out of the ordinary, so HHA-J stated she felt like the nurses did not look into it. The HHA 24 hour board shift report dated November 10, 2017 during the evening shift indicated C1 continued to have loose stools and had blood pressure readings of 138/72 and 100/69. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated she worked with C1 on Friday, November 10, 2017 during the evening shift. C1 continued to have diarrhea and back pain. C1's diarrhea was foul. HHA-G stated she had called RN-C, who was on-call that evening and reported C1's symptoms. HHA-J told RN-C she thought C1 had C-Diff and RN-C replied, she probably does. The HHA 24 hour board shift report dated November 11, 2017 during the day shift indicated C1 continued to have loose stools. The evening shift indicated C1 had strong gurgling noises was	0 880		

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0 880	Continued From page 31 put on oxygen and must monitor. C1's blood pressure was 88/50. C1's progress notes were reviewed. On Saturday, November 11, 2017 on the evening shift, HHA-G documented C1 had wheezing and her oxygen saturation was 82% on room air. C1 was placed on oxygen at two liters per minute and after 15 minutes, C1's oxygen saturation increased to 87%, During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on Saturday, November 11, 2017, C1 was totally incoherent and her blood pressure was low. HHA-G called RN-C, who was on-call, and asked the nurse to come in or allow her to send C1 to the hospital. HHA-G stated RN-C told her she could not send C1 to the hospital because C1 made up stories. HHA-G stated C1 was schizophrenic and made outlandish comments, but this sickness was not made up. C1 had previously gotten around fine and now required three staff to assist in cleaning her up. C1 previously always attended meals and had not stopped eating, was not able to walk anymore, and was completely delusional. C1's progress note dated November 12, 2017 (Sunday), LPN-E indicated C1 had low oxygen saturation, low blood pressure, and was lethargic. LPN-E contacted RN-C, who directed C1 to be sent to the hospital. C1 was transported at 8:17 a..m. C1's progress notes dated November 5 through 14, 2017 lacked any progress notes by an RN. C1's record lacked a change in condition RN assessment.	0 880		

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0 880	Continued From page 32 C1's hospital records were reviewed. On November 12, 2017, C1 was diagnosed with septic shock (total body infection) and renal failure. C1 was intubated (started artificial breathing), and given antibiotics and intravenous fluids. C1's condition worsened and was transferred to a secondary hospital on November 13, 2017. At the secondary hospital, C1 underwent exploratory surgery, confirmed sepsis was related to C-Diff and had a removal of her colon. Despite life saving efforts, C1 died on November 14, 2017. C1's death record indicated cause of death was related to C-Diff and septic shock. During an interview on February 5, 2018 at 3:03 p.m., NP-N stated she had not received any notification from the licensee about a change in C1's condition until C1 was hospitalized on November 12, 2017. NP-N stated during her last visit with C1 on October 24, 2017, C1 was still her usual self and ambulated independently. C1 had chronic kidney disease, chronic obstructive pulmonary disease, and chronic artery disease. NP-N stated the effect of C-Diff definitely would have stressed C1's body. During an interview on February 6, 2018 at 9:07 a.m., HHA-H stated shortly after C1 passed away, she had received text messages from RN-C harassing and accusing her for submitting a vulnerable adult report to Minnesota Adult Abuse Reporting Center for RN-C's actions with C1. HHA-H stated RN-C and HM-A removed her off her full time schedule doe two weeks and placed in the float position, which results in a loss of work hours and pay. HHA-H stated she showed the text messages and voiced her concerns about RN-C to HM-A, and was	0 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21049	A. BUILDING: _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

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0 880	Continued From page 33 eventually allowed her to return to her regular work schedule. During an interview on January 19, 2018 at 4:45 p.m., anonymous staff (AS)-D stated on December 8, 2017, HHA-G reported registered nurse (RN)-C made her delete an progress note entry she had made on C1 on November 11, 2017. AS-D stated she had received a phone call from the State Department of Health inquiring about C1 and transferred the phone call to RN-C. AS-D saw on RN-C's desk faxed paperwork on C1, including the progress notes and observed, the entry made by HHA-G was not included. During an interview on January 22, 2018 at 3:35 p.m., AS-B stated HHA-G reported RN-C made her delete her progress note. AS-B went into the electronic system and verified the note was deleted and reviewed the deleted note. AS-B stated RN-C reported she had to give further system access to HHA-G in order for the note to be deleted. AS-B stated she informed HM-A, and HM-A stated she was aware the note was deleted. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on December 8, 2017, the coroner called regarding C1, and RN-C told her she needed to remove her note. HHA-G stated RN-C reprimanded her for making the note, stated she was not allowed to make nurse notes, and was in violation of the licensee policy. HHA-G stated RN-C gave her administrative access to remove the note. HHA-G stated she knew it was wrong to remove a note from a medical record and reported it. During an interview on January 19, 2017 at 5:00 p.m., HM-A stated she was aware of the deleted	0 880		

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0 880	Continued From page 34 note. RN-C disciplined HHA-G because she wrote a note and was not a nurse. When inquired why HHA-G was disciplined and note the other three HHAs, HM-A stated because HHA-G applied oxygen without a doctors order and was not supposed to provide a treatment. During an interview on February 6, 2018 at 9:47 a.m., RN-C stated applying oxygen is a part of the licensee standing orders and she taught all HHA's house to use an E-tank (oxygen) during the oxygen class. During an on-site visit on January 19, 2018, the deleted note was recovered from the electronic medical record. The note was verified that it was entered on November 11, 2017 by HHA-G. The note read: "Resident found in room tonight at about 9:30 with a strong wheezing gurgling sound from what appears to be her throat, listen to lungs and didn't appear to noise from them. Her temp was at 95.1 O2/82 P/96 R/15 BP/85/50. Put resident on oxygen at 2 liters residents O2 went up to 87 within 15 minutes. Monitoring BP and O2." (O2 = oxygen saturation, P = pulse, R = respirations and BP = blood pressure). The note was verified have be been deleted on December 8, 2017 and it was verified the State Department of Health did contact the licensee for information regarding C1. The licensee electronic medical record, electronically signed entries by the logged in user, there for, titles of staff were listed behind the name of the staff member making an entry. An HHA could not have dictated a note as nurse. C1's progress notes for November 2017 had three HHA staff make an entry aside from HHA-G.	0 880		

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01080	Continued From page 35	01080		
01080 SS=E	144A.4794, Subd. 3 Contents of Client Record Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights;	01080		

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01080	Continued From page 36 (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain client records for 1 of 3 client's (C1) reviewed. C1's progress note about a change in condition was deleted from the electronic record and home health staff were instructed they could no longer document in the client records. 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 a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1's medical record was reviewed. C1 was admitted with diagnoses that included schizophrenia and asthma. C1's undated service	01080		

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01080	Continued From page 37 plan indicated C1 was independent with ambulation with a walker, dressing, grooming, eating and toileting. C1 was continent. C1 required assistance with bathing and medication administration. C1 progress notes were reviewed. On November 10, 2017, home health aide (HHA)-J made an entry indicating C1 had loose stools all shift and C1 had back pain. On November 12, 2017, licensed practical nurse (LPN)-E made an entry indicating C1 had low oxygen, low blood pressure, loose stools, and was lethargic. C1 was transported to the hospital. C1's hospital records were reviewed. On November 12, 2017, C1 was diagnosed with septic shock (total body infection) and renal failure. C1 was intubated (started artificial breathing), and given antibiotics and intravenous fluids. C1's condition worsened and was transferred to a secondary hospital on November 13, 2017. At the secondary hospital, C1 underwent exploratory surgery, confirmed sepsis was related to C-Diff, and had a removal of her colon. Despite life saving efforts, C1 died on November 14, 2017. C1's death record indicated cause of death was related to C-Diff and septic shock. C1's record lack a progress note entry made on November 11, 2017. During an interview on January 19, 2018 at 4:45 p.m., anonymous staff (AS)-D stated on December 8, 2017, HHA-G reported registered nurse (RN)-C made her delete an progress note entry she had made on C1 on November 11, 2017. AS-D stated she had received a phone call	01080		

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01080	Continued From page 38 from the State Department of Health inquiring about C1 and transferred the phone call to RN-C. AS-D saw on RN-C's desk faxed paperwork on C1, including the progress notes and observed that the entry made by HHA-G was not included. During an interview on January 22, 2018 at 3:35 p.m., AS-B stated HHA-G reported RN-C made her delete her progress note. AS-B went into the electronic system and verified the note was deleted and reviewed the deleted note. AS-B stated RN-C reported she had to give further system access to HHA-G in order for the note to be deleted. AS-B stated she informed house manager (HM)-A, and HM-A stated she was aware the note was deleted. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on November 11, 2017, she made a progress note in C1's electronic record. HHA-G stated she was instructed to make the note and place on oxygen on C1 that Saturday evening by RN-C, who was on-call. HHA-G stated on December 8, 2017, the coroner called regarding C1 and RN-C told her she needed to remove her note. HHA-G stated RN-C reprimanded her for making the note and stated she was not allowed to make nurse notes and was in violation of the licensee policy. HHA-G stated RN-C gave her administrative access to remove the note. HHA-G stated she knew it was wrong to remove a note from a medical record, and reported it. During an on-site visit on January 19, 2018, the deleted note was recovered from the electronic medical record. The note was verified that it was entered on November 11, 2017 by HHA-G. The note read: "Resident found in room tonight at about 9:30 with a strong wheezing gurgling sound	01080		

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01080	Continued From page 39 from what appears to be her throat, listen to lungs and didn't appear to noise from them. Her temp was at 95.1 O2/82 P/96 R/15 BP/85/50. Put resident on oxygen at 2 liters residents O2 went up to 87 within 15 minutes. Monitoring BP and O2." (O2 = oxygen saturation, P = pulse, R = respirations and BP = blood pressure). The note was verified have be been deleted on December 8, 2017 and it was verified the State Department of Health did contact the licensee for information regarding C1. The licensee electronic medical record, electronically signed entries by the logged in user, therefore, titles of staff were listed behind the name of the staff member making an entry. An HHA could not have dictated a note as nurse. C1's progress notes for November 2017 had three HHA staff make an entry aside from HHA-G. During an interview on January 19, 2017 at 5:00 p.m., HM-A stated she was aware of the deleted note. RN-C disciplined HHA-G because she wrote a note and was not a nurse. When inquired why HHA-G was disciplined and note the other three HHA's, HM-A stated because HHA-G applied oxygen without a doctors order and was not supposed to provide a treatment. During an interview on February 6, 2018 at 9:47 a.m., RN-C stated applying oxygen is a part of the licensee standing orders and she taught all HHA's house to use an E-tank (oxygen) during the oxygen class.	01080		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3010 0001 4648 6385

March 7, 2018

Administrator
Minnesota Heritage House
920 Southeast Fourth Street
Little Falls, MN 56345

RE: Complaint Number HL21049048

Dear Administrator:

A complaint investigation (#HL21049048) of the Home Care Provider named above was completed on February 8, 2018, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These violations occurred prior to the date of Minnesota Heritage House closing. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting 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 statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Crow Wing County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services