Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL24162006C/ HL24162005M

Date Concluded: August 10, 2021

Name, Address, and County of Licensee Investigated:
Hyatt House
231 Washington Avenue
PO Box 10
Holdingford, MN 56340
Stearns 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):
It is alleged: The facility neglected the client when they failed to provide necessary services and care for the client after the client had a significant change of condition. This resulted in the client experiencing undue discomfort and suffering in the days prior to his death.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility was responsible for the maltreatment. The client had a significant change in condition including weakness, inability to care for himself, discomfort, and unresponsiveness. The client began end-of-life hospice care. The facility failed to communicate with hospice regarding the clients ongoing significant decline in condition resulting in inadequate care and lack of supplies, inducing unnecessary discomfort and loss of dignity for the client prior to his death.

The investigation included interviews with facility staff members, including administrative and nursing staff. The client's medical records, employee records and training, facility policies and

procedures, and outside medical records were reviewed. In addition, the investigator contacted outside providers.

The client's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), and lymphedema with open wounds. The client's service plan indicated he received meal services, hygiene set up and reminders, housekeeping services, and medication management. The client was independent with most activities of daily living.

Review of the client's hospice records indicated the hospice nurse advised the facility staff to contact the hospice agency with any questions or if the client had a change of condition. The hospice notes written four days after admission for services indicated the client was alert, oriented, and could walk to the bathroom. On the fifth day of hospice care, the client had no scheduled hospice visits. Hospice notes indicated facility staff contacted the hospice social worker to discuss funeral arrangements the evening of the fifth day and mentioned to the social worker the client was unresponsive. The social worker alerted hospice nursing about the client's condition change. On the sixth day of hospice care, hospice nursing came to the facility to evaluate the client. On arrival at the facility, the client was unresponsive in a recliner without briefs and was saturated with urine. The Facility and hospice staff were not able to move, reposition, or provide care to the client due to lack of adequate equipment and the client's significant decline. The hospice notes indicated the client was restless, moaning in pain, and had a fever of 102 degrees Fahrenheit. The facility staff did not medicate the client with available pain medication, and the hospice notes indicated the facility "underused" pain medication and nebulizers when the client needed them. The facility staff reported to the hospice nurse the client had slid out of the recliner the previous night and the facility had to call the fire department to lift him back into the recliner. The client was no longer able to lie in a normal bed due to his COPD and inability to breathe lying flat, so the client had been sleeping in the recliner. The hospice notes indicated the client's lower extremity wounds were draining moderate amounts of serous fluid directly onto the chair without a pad. The hospice nurse advised the facility staff the client should have been in a hospital bed since his decline early on the fifth day of hospice care. The hospice notes indicated the facility did not contact the hospice nurse when the client became unresponsive, developed a fever, had an increase in pain, slid out of the recliner, or that the facility staff were unable to provide necessary care to the client due to the decline in condition. When hospice staff became aware of the client's significant decline in condition and the inability for facility staff to provide the necessary care, hospice ordered a hospital bed and sling for the client. The facility received the equipment to care for the client within hours.

The client's facility progress notes contained no documentation regarding the client's change of condition, fall out of the recliner, contact with the fire department, or contact with the facility nurse or hospice nurse regarding the clients decline and inability of staff to provide the necessary care to the client. On the fifth day of hospice admission, the facility staff documented the client was unable to eat, take his pills, was very weak, and unable to hold a

conversation. There is no indication the facility contacted the hospice nurse to notify them of the clients significant decline and the inability of the facility to provide cares to the client.

During interview the facility staff stated the client was on hospice and declined quickly. Facility staff stated it was the hospice's responsibility to obtain the correct equipment for the client. Staff reported unlicensed staff are to contact the housing manager or RN with changes of conditions, either in person, by email or in progress notes.

When interviewed hospice staff stated when arriving to the facility six days after the client had been admitted for hospice care, the client was disheveled. The client was unresponsive, moaning, and had a fever of 102 degrees Fahrenheit. The client was lying in his own urine without a brief, and his lower extremity wounds were draining and "stuck" to the recliner. Hospice staff stated the facility did not call the hospice nurse to report the client's decline or condition changes. Hospice staff stated nursing ordered a hospital bed and sling for the client when she saw his condition and the inability to provide the necessary care to the client. The equipment [mechanical lift for transferring and a hospital bed] arrived within hours to the facility.

Review of the facility's change of condition policy stated staff will alert the facility registered nurse of any change in client condition and the nurse will then send updates as needed to keep providers informed.

On review of facility incident reports, there was no report for the client's fall and need for fire department assistance.

In conclusion, neglect was substantiated. The facility failed to notify the hospice nurse of the client's condition changes, resulting in undue discomfort and loss of dignity in the days prior to the client's death.

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, client is deceased.
Family/Responsible Party interviewed: No family involved.
Alleged Perpetrator interviewed: N/A

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

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H24162	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYATT HOUSE LLC	231 WASHINGTON ST PO BOX 10 HOLDINGFORD, MN 56340

(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 July 1, 2021, the Minnesota Department of Health initiated a maltreatment investigation of complaint #HL24162005M/HL24162006C. At the time of the investigation, there were #11 clients receiving services under the comprehensive license. The following correction order is issued for #HL24162005M, tag identification 325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states " Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	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	0 325		

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0 325	Continued From page 1 chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one or one clients, C1, reviewed was free from maltreatment. The client was neglected when the facility failed to report a change of condition to providers, resulting in inadequate care of the client. Findings include: On August 10, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred. There was a preponderance of evidence that maltreatment occurred and the facility was responsible for the maltreatment.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	