*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** HL25202015M
**Compliance #:** HL25202016C

**Date Concluded:** May 7, 2021

**Name, Address, and County of Licensee Investigated:**
Triple Angels Healthcare Company
7150 West Point Douglas Road South
Cottage Grove, MN 55016
Washington County

**Facility Type: Home Care Provider**

**Investigator's Name:**
Jana Wegener, RN, Special Investigator

**Finding: Substantiated, facility responsibility**

**Nature of Visit:**
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

**Allegation(s):**
It is alleged the facility neglected to monitor the clients blood glucose and provide care for the client as ordered during an episode of hypoglycemia (low blood glucose). As a result, the client's blood glucose continued to drop causing a seizure and hospitalization.

**Investigative Findings and Conclusion:**
Maltreatment is substantiated. The facility was responsible for the neglect. The facility failed to ensure the clients care plan and service agreement included orders and instructions to staff for the care of the client during an episode of hypoglycemia. In addition, the facility failed to report recurring episodes of hypoglycemia to the physician as ordered leading up to the incident.

The investigation included interviews with facility staff members, including administrative, nursing, and unlicensed staff. The facility policy and procedures, staff training, prior facility incidents, staff schedules, the client's facility, clinic, emergency, and hospital medical records, were reviewed.

The client was admitted to the facility with diagnoses including hypoglycemia (a deficiency of glucose in the bloodstream), and Diabetes Type 1. The client's Vulnerability Assessment identified the client was at risk for inconsistent blood glucose.

The client's physician orders directed facility staff to do the following if the client had low blood glucose readings:
Glucose chewable tablets; a Glucagon emergency kit (ekit); and Glucagon 3mg/dose powder nasal spray. If there was no response (an increase in blood glucose) after 15 minutes, an additional 3mg dose may be administered while waiting for emergency assistance. The physician orders directed to recheck the client's blood glucose 15-20 minutes after administering glucose, and to notify the physician if the client's blood glucose was low more than two to three times per week.

The client's October Medication Administration Record (MAR) included documentation of 9 separate occasions the client required Glucose tablets for hypoglycemia. The clients medical record contained no information regarding notifying the physician of the clients multiple and ongoing low glucose levels.

The client's facility medical record indicated one night facility staff administered four glucose tablets for a blood glucose reading of 78. The clients blood glucose was not rechecked again for one hour, and at that time the clients blood glucose had dropped to 41. The facility staff administered another four glucose tablets. There was no indication the unlicensed staff contacted the facility on call nurse regarding the client's low blood glucose. One hour and 10 minutes after the clients last blood glucose reading of 41, staff entered the client's room to check on her and the client was having a seizure and was unresponsive. The staff called 911 and the client was transported to the hospital by ambulance.

C1's Emergency and hospital records indicated Emergency Medical Services (EMS) were not able to get a blood glucose reading when arriving to the facility due to the clients blood glucose level being too low. C1's initial blood glucose after arriving to the Emergency Department was 17.

The client's Service Plan indicated staff should notify the nurse on call for high or low blood glucose. The Service Plan failed to provide specific staff direction including all interventions for hypoglycemia as ordered by the provider including frequency of monitoring the clients blood glucose levels, and the use of Glucagon nasal or Glucagon e-kit.

The client's Care Plan failed to include instructions for the frequency of monitoring the clients blood glucose levels during an episode of hypoglycemia, interventions including administration of the Glucagon nasal or e-kit, and when to notify the nurse.

When interviewed the Registered Nurse stated she was unaware the clients Service agreement and Care Plan lacked the specific physician orders to instruct staff on what to do when the client had an episode of hypoglycemia.

In conclusion, neglect was substantiated.

**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.

**Vulnerable Adult interviewed**: No.

**Family/Responsible Party interviewed**: Attempt, no response.

**Alleged Perpetrator interviewed**: N/A

**Action taken by facility:** No Action Taken

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc: The Office of Ombudsman for Long-Term Care

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | H25202 | A. BUILDING: _____ B. WING _____ | C 03/25/2021 |

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| TRIPLE ANGELS HEALTHCARE CO | 7150 W POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On March 25, 2021, the Minnesota Department of Health conducted an investigation of complaint #HL25202015M, and #HL25202016C. At the time of the survey, there were # 12 clients receiving services under the comprehensive license.<br><br>The following correction orders are issued for #HL25202015M, and #HL25202016C, tag identification 0265, and 0325. | 0 000 | The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b). | |
| 0 265 SS=G | 144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice<br><br>Subdivision 1.Statement of rights. (a) A client who | 0 265 | | |

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| 0 265 | Continued From page 1<br>receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights:<br>(2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards, and up to date plan of care following providers orders for one of one client (C1) reviewed. The licensed facility staff failed to notify C1's health care provider of recurring low blood glucose levels leading up to an incident of hypoglycemia dropping to 17 causing a seizure and hospitalization. In addition, during the incident of hypoglycemia requiring hospitalization, facility staff failed to monitor the client, notify the on-call nurse, and implement interventions ordered by the provider for the client during an episode of hypoglycemia.<br><br>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 a 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). | 0 265 | | |

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| 0 265 | Continued From page 2<br>The findings include:<br><br>C1 was admitted to the facility on May 8, 2019, with diagnoses including hypoglycemia (a deficiency of glucose/low blood glucose in the bloodstream) and diabetes Type 1 (a chronic condition where the body produces little or no insulin).<br><br>C1's physician "After Visit Summary" (AVS) dated September 23, 2020, included instruction to notify the provider if the client had hypoglycemia more than two to three times per week.<br>C1's AVS included orders for glucose (BD GLUCOSE) 4 chewable tablets/15 grams, Glucagon 3 mg/dose powder, and Glucagon 1 mg Emergency Kit. The AVS instructions indicated signs and symptoms of hypoglycemia included nervousness, sweating, intense hunger, trembling, weakness, palpitations, and difficulty speaking. The AVS instructions indicated acute management of hypoglycemia included the rapid delivery of a source of easily absorbed sugar including regular soda, juice, lifesavers, or table sugar, or 15 grams of glucose followed by an assessment of symptoms and a blood glucose check 10 minutes after administration. If no improvement, another 10-15 grams of glucose should be given, and indicated the glucose administration could be repeated up to three times. The AVS instructions indicated when blood glucose fell below 50 the patient could be unable to talk or take oral therapy, and recommended Glucagon administration for the patient at that time.<br><br>A review of the document titled "90 Day Nurse Reassessment Visit with Medication Management" dated October 7, 2020, indicated C1 required medication management and | 0 265 | | |

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| 0 265 | Continued From page 3<br><br>medication administration by facility staff. The assessment indicated C1 required continuous monitoring and supervision due to blood glucose fluctuations utilizing a continuous blood glucose transmitter.<br><br>C1's Medication Administration Record (MAR) included the following orders:<br>- Glucose 4 tablets/15 grams by mouth as needed for hypoglycemia for low blood glucose less than 80.<br>- Glucagon emergency kit.<br>- BAQSMI Glucagon 3 milligrams (mg) dose powder spray, with instructions to administer 3 mg in each nostril as needed for hypoglycemia. If the clients blood glucose remained low after 15 minutes an additional 3 mg dose may be administered while waiting for emergency assistance.<br><br>C1's October, 2020, MAR documentation included administration of nine separate doses of Glucose tablets given to the client for hypoglycemia as follows:<br>- On October 6, 2020, at 11:44 a.m.<br>- On October 9, 2020, at 11:15 a.m.<br>- On October 13, 2020, at 9:16 p.m.<br>- On October 14, 2020, at 5:20 p.m., and two additional doses on that day with illegible times.<br>- On October 15, 2020, at 9:20 p.m.<br>- On October 16, 2020, at 11:00 p.m.<br>- On October 17, 2020, at 11:12 p.m.<br><br>C1's facility and clinic medical records had no documentation of the facility notifying the provider of any of the nine episodes of hypoglycemia in the two weeks leading up to the incident as ordered by the provider. | 0 265 | | |

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| 0 265 | Continued From page 4<br><br>The facility document titled "Incident/Accident Report" dated October 22, 2020, at 4:40 a.m. indicated the client had low blood glucose that night and staff administered glucose tablets, then the client began to have a seizure and was unresponsive, staff called 911 immediately. The incident section for corrective action taken indicated the client had a history of low blood glucose with seizures, and staff called 911 as instructed, and no corrective action was taken.<br><br>C1's Progress Note dated October 22, 2020, indicated around 2:30 a.m. during rounds C1's blood glucose was noted to be 78 and staff administered four glucose tablets. One hour later at 3:30 a.m. the progress note indicated C1's blood glucose was rechecked and had dropped to 41, staff administered an additional four glucose tablets at that time. The progress notes indicated at 4:40 a.m. one hour and 10 minutes after the clients last checked blood glucose reading of 41, staff went to observe the client and found her unresponsive and having a seizure, then called 911.<br><br>C1's Emergency and hospital records indicated Emergency Medical Services (EMS) were not able to get a blood glucose reading when arriving to the facility due to the clients blood glucose level being too low. The records indicated the facility staff did not know the clients last known well time. EMS obtained an intraosseous vascular access (The process of supplying urgently needed fluid into the marrow cavity of a bone in a life-threatening condition in which normal access to the circulation is difficult) at 5:10 a.m. a D10 (a 10 percent dextrose solution) and versed (a medication that is commonly used as emergency treatment for seizures) was given. C1's initial blood glucose after arriving to the Emergency | 0 265 | | |

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| 0 265 | Continued From page 5<br>Department was 17.<br><br>C1's "Service Plan" dated January 16, 2020, included service descriptions for checking the client's blood glucose five to six times daily and as needed, and indicated if her blood glucose was less than 80, staff were to treat the clients low blood glucose with four glucose tablets. The service plan did not indicate how many times the glucose tablets could be repeated. The service plan did not include other interventions for hypoglycemia ordered by the provider including frequency of monitoring during an episode of hypoglycemia, and the utilization of the Glucagon ekit, or BAQSMI Glucagon nasal spray. The Service Plan indicated staff should notify the registered nurse with high and low blood glucose readings, and instructed staff to call the provider for high blood glucose over 400. The service plan failed to include specific parameters for the clients "high and low" blood glucose.<br><br>C1's "Care Plan" dated January 16, 2020, indicated the client required blood glucose monitoring, and instructed staff to check on the client every 15 minutes for sluggish unresponsive episodes due to hypoglycemia. The care plan instructed staff to check the clients blood glucose and offer four glucose tablets, then re-check her blood glucose in 15 minutes. The care plan failed to include instructions for when to repeat the glucose tablets, and did not include the use of Glucagon ekit, or BAQSMI Glucagon Nasal Spray as ordered by the provider. In addition, the care plan lacked instructions for staff to call the nurse with low or high blood glucose as indicated in the service agreement.<br><br>A review of facility provided staff diabetic education included how to obtain a blood glucose | 0 265 | | |

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| 0 265 | Continued From page 6<br><br>sample using a glucometer. No other information was provided.<br><br>The facility document titled "Daily Log Notes" (a staff shift to shift report) included an entry dated October 22, 2020, at 5:00 a.m. by personal care assistant (PCA)-C who indicated when she arrived to the facility for her shift the client was convulsing and unresponsive. The note indicated PCA-D was on the phone with emergency medical services (EMS) and the client was transferred to the hospital at 5:30 a.m.<br><br>During interview on April 22, 2021, at 9:06 a.m. Director of Nurses (DON)-B stated she does not provide diabetic education for staff. DON-B stated staff followed the providers orders, and indicated she knows staff are competent and know what to do because they sign off on the MAR. The DON stated staff had no training on hypoglycemia other than parameters set by the provider, and indicated staff had no other diabetic training or education provided. DON-B stated C1 was like a 1:1 with staff for blood glucose monitoring and has hypoglycemia episodes up to 10 times daily. DON-B stated C1's continuous glucose monitoring system would alert for high or low blood glucose levels and C1 would alert staff. The DON stated the night of C1's incident staff noticed C1 had low blood glucose and administered glucose tablets then waited a while to re-check her. DON-B stated staff have to wait to recheck the clients blood glucose and they did that, then when they did it was lower and C1 was unresponsive having a seizure. DON-B stated C1 did not alert staff of a low blood glucose that night but stated the level must have been below 70 because the staff administered glucose tablets.<br><br>When interviewed on April 23, 2021, PCA-D | 0 265 | | |

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| 0 265 | Continued From page 7<br><br>stated she worked with C1 the night of the incident. PCA-D stated she was hired a few days prior to the incident and was working alone that night. PCA-D stated C1 had an implanted meter that you touch and gave the blood glucose reading. PCA-D stated at 2:30 a.m. the client came out of her room and stated she needed glucose. PCA-D stated she checked C1's meter and the number was low, so she gave C1 four glucose tablets. PCA-D stated at 3:30 she re-checked the clients blood glucose, and it was low again and the meter was red, so she gave four more glucose tablets. PCA-D stated she was not trained to know what the red light meant on the client's meter and did not know what could happen if someone's blood sugar got too low. PCA-D stated she had rechecked the client often through the night and C1 was awake, talking, and reading her book. PCA-D stated C1 seemed good and did not check the meter to see what her blood glucose was between 2:30, and 3:30 a.m. PCA-D stated at 3:30 a.m. C1 was still awake, and she observed her take the four glucose tablets, then a while later C1 was having a seizure. PCA-D stated she did not know what to do and called PCA-C who instructed her to call 911. PCA-D stated she called 911 right away. PCA-D stated she called PCA-C because she was scheduled to work the next shift. PCA-D indicated she was not aware she should report low blood glucose to the nurse on call and was not aware there was a nurse available to call at night. PCA-D stated she was scared and worried for C1 and felt like her training and orientation had not prepared her for what could happen if a client's blood glucose was low.<br><br>During interview on May 6, 2021, at 11:05 a.m. PCA-G stated she was instructed to read and follow the care plan for specific guidelines to care | 0 265 | | |

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| 0 265 | Continued From page 8<br><br>for each client. PCA-G stated she had worked with C1 and never really knew what her protocol was for hypoglycemia. PCA-G indicated she was not trained on what the red alarming of C1's glucometer meant, and indicated she was not aware C1 used Glucagon nasal spray or ekit, and stated she was never trained on how to use either. PCA-G stated if C1's blood glucose was low staff were instructed to use the glucose tablets. PCA-G stated she received no diabetic training during orientation, but they did cover some general information during a staff meeting.<br><br>During interview on May 6, 2021, at 3:00 p.m. PCA-I stated she was trained to follow the clients nursing care plan for what to do if a client was diabetic. PCA-I stated the usual staffing on a night shift was two staff. PCA-I stated she was not aware C1 had Glucagon and had received no training on how to administer Glucagon.<br><br>During a follow up interview on May 10, 2021, at 9:30 a.m. DON-B stated PCA- D had no prior experience in healthcare. DON-B stated PCA-D was supposed to be training and she did not know why she was working alone. DON-B stated it was normal to have two staff scheduled to work the night shift, and indicated as far as she knew PCA-D, and PCA-C were working together the night of the incident. DON-B stated staff did not call her to report C1's low blood glucose and indicated she was not notified until PCA-C called her and told her C1 was unresponsive and having a seizure. DON-B indicated she had instructed staff to call 911, which they had already done. DON-B stated she felt the facility was usually on top of reporting low blood glucose readings to the provider and stated "it must have fallen through the cracks". DON-B stated she would expect staff to notify her immediately of low blood glucose | 0 265 | | |

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| 0 265 | Continued From page 9<br>readings, and they did not.<br><br>The undated facility provided policy and procedure titled "When to Call the Nurse" stated in general the nurse should be contacted in any unusual circumstance, and instructed staff to review the Care Plan for client specific parameters. The policy and procedure included reasons to call the nurse in the event of medication side effects, change in skin color temperature such as cool clammy, change in mental status, change in appearance or lethargy, change in sleep or behavior patterns, and encouraged staff to call the nurse when in doubt or unsure about something.<br><br>The facility provided policy and procedure titled "Vulnerable Adult Protection" dated November 30, 2017, section d. Neglect was defined as the failure by a caregiver to supply the vulnerable adult (VA) with necessary healthcare or supervision, or the absence likelihood of absence to provide healthcare and supervision to a vulnerable adult. Section 3. Facility responsibilities included to admit clients for whom care can safely be provided. The policy and procedure defined caregiver as an individual or facility who has the responsibility for the care of a vulnerable adult by contract or agreement. The policy indicated when abuse or neglect was suspected the incident should be reported immediately to the Administrator or Director of Nursing and they would review the information to determine if a report should be made to MAARC within 48 hours.<br><br>Time period for correction: Seven (7) days. | 0 265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H25202 | A. BUILDING: _____ B. WING _____ | C 03/25/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TRIPLE ANGELS HEALTHCARE CO | 7150 W POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016 |

| (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 10 | 0 325 | | |
| 0 325 | 144A.44, Subd. 1(a)(14) Free From Maltreatment<br><br>Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights:<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interviews, and document review, the facility failed to ensure client one, (C1) was free from maltreatment.<br><br>Findings include:<br><br>On May 7, 2021, the Minnesota Department of Health (MDH) issued a determination that negelct occurred. The MDH concluded there was a preponderance of evidence that maltreatment occurred, and the facility was responsible for the maltreatment in the facility. | 0 325 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325. | |