Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL25824025M
Compliance #: HL25824030C

Date Concluded: September 4, 2020

Name, Address, and County of Licensee Investigated:
The Encore of the Twin Cities
2300 Hazelwood Street
Maplewood MN 55109
Ramsey County

Name, Address, and County of Housing with Services location:
The Encore of Hugo
5607 150th Street North
Hugo, MN 55038
Washington County

Facility Type: Home Care Provider

Investigator's Name:
Carol Moroney, RN Special Investigator
Angela Vatalaro, RN Special Investigator
Rhylee Gilb, RN Special Investigator
Supervisor

Finding: Substantiated, facility and individual 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 the client fell and sustained a lumbar (L5) spine fracture.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the alleged perpetrator were responsible for the maltreatment. The facility and the alleged perpetrator (AP) failed to assess, monitor, or provide interventions for the client after changes of condition. The client sustained a lumbar (L5) spine fracture and passed away five days later.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included an onsite visit with observations

and interviews. The investigation included review of the client's medical record. Finally, the investigation included an interview with the AP.

The client's medical record was reviewed. The client's diagnoses included heart disease, chronic kidney disease, and Alzheimer's disease. The service plan indicated the client required assistance with medication administration, bathing, dressing and grooming, continence care daily, walking assistance as needed, escorts as needed due to confusion and a daily wellness check. The client was able to walk independently. However, the client's vulnerability assessment and individual abuse prevention plan indicated the client was not oriented to person, place or time; was not able to ambulate safely with or without a device; had a history of chronic conditions; was not able to call for help; and had a history of falls.

One day, the client's progress notes indicated the client had fatigue and lower back pain. The client also had a temperature of 99.5 degrees Fahrenheit. The AP, a registered nurse, contacted the client's physician and ordered laboratory work for a urine analysis and culture, a COVID-19 test, and an influenza test. Two days later, the client's urine analysis came back positive for a urinary tract infection and started an antibiotic as well as a controlled pain medication scheduled at bedtime.

The AP failed to assess the client's change in needs during an infection and implement additional assistance or services for the client's activities of daily living (ADL's).

Five days later, the AP documented the client was still fatigued, had a new decrease in appetite, and the client's COVID-19 test was positive. The AP failed to complete an assessment of the client's change in needs, status of her urinary tract infection, or COVID-19 infection, and failed to implement services to support the client's ADLs.

One week later, the AP requested an antidepressant from the client's physician due to loss in appetite and the physician ordered a daily antidepressant. The next day, the client fell in her closet. The AP documented the client had a scrape on her back and a bruise. The AP requested another order from the client's physician for a urine analysis and culture. The AP failed to assess the client for changes in needs and implement any preventative fall interventions.

The next morning, the client fell a second time and staff found the client laying on her stomach next to her bed on the floor. The client complained of back pain and staff sent the client to the hospital for evaluation. The client's hospital records indicated the client had a new lumbar spine fracture. The client returned to the facility the next day on hospice services.

The AP failed to do a change in condition assessment of the client for starting hospice services and failed to implement new services to assist the client as she was actively dying.

The client's death record indicated the client died four days after returning to the facility from the hospital. The client's cause of death was complications of COVID-19.

During an interview, the AP stated after a client falls, she increases safety checks, checks the room for clutter and trip hazards, makes sure lights are working, and increases toileting frequencies. The AP stated interventions are added to the service plan. The AP stated the client was at a risk for falls when she stopped eating and became weaker. The AP stated her intervention from the first was to obtain another urinary analysis. The AP stated she did not do nursing assessments. She stated she updates the service plan and vulnerability assessments. When asked how she knows what to update on the service plan without a nursing assessment she stated “I know my residents very well” and she updates the service plan based on care needs. The AP also stated she followed company policies, not regulations.

During an interview, regional director of wellness stated the facility RN is to do a nursing assessment every 90 days or with any change of condition.

During an interview, the administrator stated he was aware of the clients two falls, fracture, and death. When asked if he was aware there were no interventions in place for the client’s fall, he stated he did not review the service plan.

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. The client is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP nurse had the client tested for infections. Staff sent the client to the hospital following the second fall for evaluation.

Action taken by the Minnesota Department of Health:
The Minnesota Department of Health deferred review for disciplinary action of the AP to the Minnesota Board of Nursing.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C

cc:
The Office of Ombudsman for Long-Term Care
Washington County Attorney
Hugo City Attorney
Hugo Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H25824	A. BUILDING: _____ B. WING _____	C 07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT THE TWIN CITIES	2300 HAZELWOOD STREET NORTH MAPLEWOOD, MN 55109

(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 a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On June 30, 2020, the Minnesota Department of Health initiated an investigation of complaint #: HL25824021M; HL25824023M;HL25824025M; HL25824028M; HL25824027C; HL25824024C; HL25824030C; HL25824029C. At the time of the investigation, there were seven clients receiving services under the comprehensive license. The following correction orders are issued for # HL25824021M; HL25824023M;HL25824025M; HL25824028M; HL25824027C; HL25824024C; HL25824030C; HL25824029C, tag identification 1252.	0 000	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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
01252 SS=K	144A.4798, Subd. 3 Infection Control Program Subd. 3.Infection control program. A home care provider must establish and maintain an effective	01252		

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01252	Continued From page 1 infection control program that complies with accepted health care, medical, and nursing standards for infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19. This practice resulted in a level four violation (a violation that results in 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: The licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control that included screening of employees when entering the building; screening and monitoring clients; screening essential healthcare workers; compliance to COVID-19 practices of isolating clients and proper usage of personal protective equipment (PPE). In addition, the licensee failed to complete routine quality of care audits to ensure compliance with the infection control guidelines. This resulted in harm to eight clients according to the registered nurse/director of wellness and the administrator.	01252		

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01252	Continued From page 2 On June 30, 2020, at approximately 9:50 a.m., employee A (administrator/unlicensed personnel/ULP) allowed entry into the building. The essential healthcare workers were not screened upon entry. Employee A stated all staff and essential healthcare workers entered through the main entry. Employee A stated no one uses the side doors. On June 30, 2020, at approximately 10:00 a.m., employee B (registered nurse/RN) stated "all of the deaths in the facility recently were COVID," then she hesitated and said most of the deaths we have had were COVID. EMPLOYEE SCREENING On June 30, 2020, at approximately 10:00 a.m., employee B entered the facility, employee B was observed coughing. When asked about the cough, employee B stated my cough started last night and I have a sore throat. Employee B also stated she did not do an employee screening when entering the building that day. Employee B provided a stack of employee screening but the papers were out of order. No line list of employees were provided. Employee B stated the staff do their screening and put them in her box. She reviews the papers the next time she works. She does not monitor the papers to ensure all of the staff who worked every shift were screened. SCREENING AND MONITORING OF CLIENTS On July 1, 2020, at approximately 1:00 p.m. employee F (RN/regional director of wellness) confirmed the licensee's expectation was clients need to be screened twice daily. Employee F confirmed the client screening	01252		

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01252	Continued From page 3 sheets provided were the most recent and only screenings. The client "Covid-19 prevention log" which included temperature, shortness of breath, sore throat, and cough. The licensee did not monitor clients' Oximetry level. The following was the screenings done per client: - C13 was screened seven times in 62 opportunities in May; - C14 was screened seven times in 62 opportunities in May; - C11 was screened five times in 62 opportunities in May; - C6 was screened seven times in 62 opportunities in May; - C18 was screened seven times in 62 opportunities in May; - C4 was screened seven times in 62 opportunities in May; - C1 was screened seven times in 62 opportunities in May; - C15 was screened seven times in 62 opportunities in May; - C16 was screened seven times in 62 opportunities in May; - C17 was screened seven times in 62 opportunities in May; - C2 was screened nine times in 62 opportunities in May; - C12 was screened eight times in 62 opportunities in May; - C3 was screened five times in 62 opportunities in May. None of the clients were screened in June 2020. ISOLATING CLIENTS On June 30, 2020, at approximately 3:30 p.m., employee G (ULP) stated when clients had been	01252		

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01252	Continued From page 4 tested for covid and the facility was waiting for the results, the ULP's were instructed to only wear a mask, goggles and gloves. They were told there was no need to wear the full isolation attire. On June 1, 2020, at approximately 11:00 a.m., employee A stated 12 or 13 clients have died from covid in the last few months who were living in the facility. Employee also stated C5 was admitted on May 4, 2020, to the facility and was not put into isolation because she wanted to be out of her room and around the other clients. C5 died on May 20, 2020. PPE (personal protective equipment) USAGE On June 30, 2020, at approximately 10:10 a.m., employee H (kitchen) stated the clients do not wear masks for source control while in public areas of facility. At that time, two clients were in the dining room without wearing a source control mask. On June 30, 2020 at approximately 10:20 a.m., employee C (housekeeping/unlicensed personal/ULP/assistant administrator) was observed not wearing eye protection in client care area, the dining room. She stated she would get goggles on. On June 30, 2020, at approximately 10:30 a.m., employee D (unlicensed personnel/ULP) was observed carrying a personal bag, walking down the hall from a side exit door. She walked past client rooms and through the dining room. When asked why she was not wearing a mask, or goggles she stated I was on my way to change my clothes for work. I will put it on after I change, the mask and goggles are in my bag. She also stated she had not received any training about	01252		

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01252	Continued From page 5 when to wear a mask and eye protection. On June 30, 2020, at approximately 11:00, a.m. employee E (an executive) was observed in the client's hallway taking pictures of the floor and walls for a future remodel project. Employee E was not wearing goggles. When asked, employee E stated no one told me to. COMPLIANCE AUDITS On June 30, 2020, at approximately 10:30 a.m., employee A (administrator) stated he was unable to provide any infection control compliance audits. An interview on July 1, 2020, at approximately 11:00 a.m., employee F (regional director of wellness/registered nurse/RN) stated the Encore quality committee has not reviewed any infection control compliance audits from the Hugo facility. An interview on July 1, 2020, at approximately 11:05 a.m., employee F stated all essential healthcare workers need to be screened at the door. Employees need to be screened at the door. Employee F stated she observed a staff person enter the building through a side entrance today and she instructed the administrator the staff need to enter the building through the front entrance. She said no staff can be working if they have a sore throat, cough, temperature, and yesterday we added gastrointestinal symptoms to the screen. Employee F stated clients need to be screened twice daily. Employee F stated essential healthcare workers need to be screened when entering the building. Employee F was not aware that presumptive clients were not isolated. Employee F said she was not aware the	01252		

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01252	Continued From page 6 employee B (RN) was sick when she was working yesterday or that she was not screened upon entry to the facility. Employee F stated employee E needs to wear eye protection when in the building. On July 1, 2020, at approximately 11:00 a.m., employee A stated all staff were trained on wearing a mask and eye protection. Employee A stated he would give us the audits for infection control and covid but not. Employee A said employee would enter through the main door from now on and all staff must stay home if they are exhibiting symptoms. The licensee's undated "Infection Control and Standard Precautions" policy lacked direction for caring for a covid 19 clients or how to prevent the spread of covid 19. The policy did address donning and doffing isolation gowns but did not address when to wear them during a covid 19 outbreak. The policy lacked instruction to screen clients, employees or essential healthcare workers. The licensee did not provide a policy about isolating clients. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01252		