DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL27377024M
Compliance #: HL27377025C

Date Concluded: September 22, 2021

Name, Address, and County of Licensee Investigated:
Inver Grove Heights White Pine II
9058 Buchanan Trail
Inver Grove Heights, MN 55077
Dakota County

Facility Type: Home Care Provider

Investigator's Name:
Jennifer Segal RN, BSN, PHN

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 clients (client 1 and client 2) when staff failed to provide adequate supervision of two clients. Client 1 walked into client 2's room looking for a bathroom which resulted in client 2 pushing client 1. Client 1 fell and sustained a right hip fracture requiring surgical repair.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Client 1 had a history of entering other clients' rooms uninvited. Client 1 was involved in two previous incidences of harm prior to the incident when client 1 entered other client's rooms uninvited. Client 2 had known history of aggressive and threatening behavior toward others that manifested in, inappropriate physical, verbal, and sexual behaviors toward others. The facility did not implement new or effective interventions to protect or prevent harm to client 1 or client 2.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted family and

responsible parties of both clients. The investigation included a facility tour with additional time actively observing the men's memory care unit. A review of facility documents included client medical records, facility policies and procedures, incident reports, personnel records, and staff training records.

Client 1 admitted to the men's memory care unit with diagnoses that included dementia without behavioral disturbances, urinary retention, and chronic kidney disease. Staff assisted the client with dressing, shaving, bathing, toileting, meals, and medication administration. Client 1's service plan indicated he received safety checks every two hours including monitoring and cueing to use his own bathroom every two hours.

Client 1's record indicated client 1 wandered into another clients room uninvited and involved in an incident of harm. The following day the licensee transferred client 1 to the men's memory unit

Client 1's record indicated six weeks after transfer to the men's memory unit a second incident of harm occurred when client 1 was looking for a bathroom walked into another clients space and pushed client 1. Client 1 fell and sustained multiple fractured ribs. Staff sent client 1 to the hospital for evaluation. Following hospitalization client 1 transferred to a transitional care unit for rehabilitation before returning to the men's memory care unit.

Client 2 admitted to the men's memory care unit with diagnoses that included dementia, major depressive disorder, and encephalopathy (brain disease). Client 2's service plan indicated he required assistance with dressing, bathing, toileting, meals, and medication administration. Client 2 received safety checks every two hours including monitoring for agitation, aggressiveness, and inappropriate behavior.

Client 2's record indicated he discharged from a previous facility due to aggressive and threatening physical, verbal and sexually inappropriate behavior reflected in a pre-screen interview and health history form conducted by the facility prior to admission to the men's memory care unit.

Client 2's initial nursing assessment and initial vulnerability and abuse prevention plan indicated client 2 had aggressive behavior toward self and others and "known to be aggressive". The assessment indicated client 2 may pose a risk to other vulnerable adults.

Ten days after client 2's admission, an incident report indicated client 2 pushed client 1 when client 1 entered client 2's room looking for a bathroom. Staff responded to yelling from client 2's room. Inside the doorway of client 2's room near the bathroom, staff found client 1 on the floor. The report indicated client 1 was looking for a bathroom when client 2 pushed client 1. Client 1 complained of leg pain and unable to bear weight on his legs. Staff sent client 1 to the hospital for evaluation. Client 1 had a fractured right hip and required surgical intervention. Following hospitalization, client 1 did not return to the facility.

During interviews with nursing staff, it was indicated that they voiced concerns to management about admissions to the men's memory unit and felt it was not manageable or safe for the staff or clients on the men's unit. Nursing staff explained the lack of a registered nurse impacted the ability to reassess client's needs and put new interventions in place.

During interviews with licensed and unlicensed staff, they indicated client 1 was frequently looking for a bathroom and needed reminders where the bathroom was located. Staff reported client 1 was pleasant and easily redirected but staff were not always able to monitor client 1. One staff member said client 1 was a "victim" of the unit when other clients on the unit were unmanageable. Unlicensed staff reported expressing concern to nursing and administrative staff about safety of the unit however, management provided no new interventions, guidance, or education to support staff or clients.

During interviews with licensed and unlicensed staff they reported feeling afraid of client 2. Staff reported client 2 was younger and more aggressive than other clients on the unit. Staff stated they notified management they needed more staff on the unit for safety of staff and clients. Staff reported calling in sick or reducing hours because they were uncomfortable and did not feel safe on the unit. Management did not respond.

During an interview with the regional director, she indicated the incident between client 1 and client 2 was a result of client 2's transition to the facility. She indicated reassessment and intervention was not necessary since it was an isolated incident. She said she was unaware of past incidents involving client 1 being harmed or harming others while looking for a bathroom. She was unsure why a registered nurse did not re-assess or implement new safety measures. She added there was frequent RN and housing manager changes compromising continuity of staff. She acknowledged at one point an agency filled in to "catch up" all missing and late RN assessments.

The investigator was unable to interview a registered nurse that worked for the facility at the time of incident between client 1 and client 2. The facility indicated frequent turnover of registered nurses. The agency nurse did not return the investigators calls.

During an interview with client 1's family member he reported he asked the facility management what they would do to protect client 1 after he was pushed and injured weeks prior in a similar scenario. Family reported the facility mentioned placing a stop sign or other visual reminders to discourage client 1 from walking into other client's rooms but the facility did not follow through. Another family member of client 1 reported visiting frequently and felt there were not enough staff on the unit to manage the client's needs. Client 1's family reported client 1 did not return to the facility following the final incident because the facility was unable to keep client 1 safe as promised.

During an interview with the responsible party for client 2, she indicated client 2 was evicted from the previous facility due to aggressive behaviors. The responsible party indicated the facility was provided with client 2's history and medical information before admission to determine if client 2's needs could be met by the facility.

The facility's policy indicated that a registered nurse would re-assess clients and identify any new vulnerabilities or risks that a client may pose to himself or other vulnerable adults.

In conclusion, neglect was substantiated.

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 1 deceased. Client 2 unable to interview due to cognitive deficits.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent client 1 to the hospital after the fall with injury.

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
Dakota County Attorney
Inver Grove Heights City Attorney
Inver Grove Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27377	A. BUILDING: ____ B. WING ____	C 08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	**9058 BUCHANAN TRAIL** **INVER GROVE HEIGHTS, MN 55077**

(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: ******REVISED****** On August 5, 2020 the Minnesota Department of Health initiated an investigation of complaint HL27377024M /HL27377025C and HL27377026M /HL27377027C. At the time of the survey, there were #28 clients receiving services under the comprehensive license. The following correction orders are issued for HL27377024M /HL27377025C and HL27377026M /HL27377027C tag identification 810 and 325.	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).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of two clients reviewed (C1, C3) was free from maltreatment. C1 and C3 were neglected. Findings include: On September 22, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction is required for tag 325. Please see public maltreatment report for details.	
0 810 SS=H	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual,	0 810		

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0 810	Continued From page 2 including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to develop and implement appropriate individual abuse prevention plans (IAPP) for 2 of 2 clients (C1, C2) reviewed. The licensee failed to appropriately assess C1's susceptibility to be abused by other vulnerable adults at the facility; failed to identify interventions to protect C1 from abuse by other vulnerable adults and did not include specific and individualized measures to reduce C1's risk of abuse despite C1's history of past abuse by another vulnerable adult in the facility. C2's IAPP did not include specific measures to reduce C2's known behavior of threatening and harmful acts toward others. C2's IAPP was not updated after C2 pushed C1 to the floor. C1 sustained a fractured hip and required surgery. C1 did not return to the facility. 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 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).	0 810		

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0 810	Continued From page 3	0 810		

The findings include:

C1's medical record was reviewed. C1 had diagnoses that included dementia without behavioral disturbances and chronic kidney disease. C1's service plan dated April 5, 2019, indicated C1 received comprehensive home care services that included medication management, personal cares, mobility, bathroom assistance, and safety checks every two hours.

C1's admission assessment dated April 5, 2019, indicated the reason for C1's admission was C1 wandered during the night into another client's room and inappropriately touched a client. The client was moved the following day to the secure men's memory unit. The admission assessment indicated C1 was alert, pleasant and social. Also indicated C1 was confused and displayed impaired decision making.

C1's vulnerability assessment and prevention plan (VAPP) dated April 5, 2019, indicated C1 was not vulnerable in behaviors that would pose a risk to himself including wandering. The assessment indicated C1 posed a risk to others through inappropriate sexual behaviors due to history of wandering into another client's room and touching a client inappropriately. There were no specific interventions in C1's VAPP staff should use to minimize the risk of abuse to C1 or other vulnerable adults and there were no specific interventions to minimize the risk of inappropriate sexual behaviors or wandering.

C1's progress note dated May 19, 2019, for an incident on May 18, 2019, at 10:30 p.m. indicated another client pushed C1 when C1 wandered into another client's room. C1 fell from being pushed and sustained several rib fractures. C1 required

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0 810	Continued From page 4 hospitalization and rehabilitation prior to returning to the facility. A progress note dated June 4, 2019, at 1:51 p.m. indicated C1 returned to the facility following the incident on May 19, 2019. C1's VAPP dated June 4, 2019 indicated C1 was not vulnerable in behaviors that would pose a risk to himself including wandering. The assessment indicated C1 posed a risk to others through inappropriate sexual behaviors due to history of wandering into another client's room and touching a client inappropriately. There were no specific interventions in C1's VAPP staff should use to minimize the risk of abuse to C1 or other vulnerable adults and there were no specific interventions to minimize the risk of inappropriate sexual behaviors or wandering. There were no new or specific interventions in place to reduce C1's risk of harm by another vulnerable adult following past incidences of harm while wandering. C1's nursing assessment dated June 4, 2019, indicated C1 lacked self-preservations skills; was unable to protect himself against potential health and safety risks. The assessment indicated C1 was pleasant and social. C1 had short and long-term memory impairments. The assessment did not identify new interventions for safety following past incidences of harm while wandering. C1's progress note dated August 6, 2019, at 12:56 p.m. indicated C1 "got up from dining table and went over by the elevator and was undoing pants to urinate in the hall" staff redirected C1 to the bathroom.	0 810		

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C1's progress note dated August 7, 2019, at 12:40 p.m. indicated C1 demonstrated inappropriate removal of undergarments while in the dining room.

An Incident Report dated October 27, 2019, at 4:00 p.m. indicated C1 wandered into C2's room to urinate. C2 pushed C1 resulting in a fall. C1 was unable to bear weight in his legs. C1 was taken by ambulance to the hospital. C1 required surgery for a fractured hip. C1 did not return to the facility.

C2's medical record was reviewed. C2 had diagnoses that included dementia, major depressive disorder, and encephalopathy (brain disease) and a history of threatening and harmful behavior toward others. C2 admitted to the secured men's memory care unit. A service plan at the time of admission was requested, not provided.

C2's admission assessment dated October 18, 2019, indicated C2 required assistance with personal cares including mobility, toileting, dressing and medication administration. The assessment indicated C2 had dementia, short term memory loss, depression, and anxiety. C2 had impaired decision making and was sexually aggressive with others.

C2's VAPP dated October 18, 2019, indicated C2 posed a risk to others by threatening behavior and a history of inappropriate sexual behaviors. C2 was "known to be aggressive". The VAPP indicated that C2 may pose a risk to other vulnerable adults.

C2's Elopement Risk Assessment dated October 18, 2019, indicated that C2 had potential risks

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0 810	Continued From page 6	0 810		

factors that included, agitation, restlessness or aggressiveness. C2 exhibited manic or obsessive and impulsive behaviors.

C2's VAPP was not updated following the incident on October 27, 2019. No specific measures or interventions were instituted to protect other vulnerable adults from C2 despite C2's history known at admission to the facility nor following the incident on October 27, 2019.

During an interview on September 29, 2020, at approximately 4:36 p.m. unlicensed personnel (ULP)-B reported the men's unit was "intense." ULP-B recalled speaking with management to request more staff and more help to learn about the behaviors on the men's unit. ULP-B reported neither were provided and it became unmanageable to work at the facility.

During an interview on October 2, 2020, at 3:37 p.m., licensed practical nurse (LPN)-H reported C1 was known to wander, sometimes with purpose, looking for a bathroom, or an activity. LPN-H stated C1 was a "victim "of the behaviors and lack of staff on the men's unit.

During an interview on October 29, 2020, at 4:12 p.m. with C1's family member (FM)-T recalled asking the licensee in May 2019 how the licensee would protect C1 from another injury. FM-T reported the licensee discussed placing a stop sign on a door to deter C1 from wandering into a client's room, but this did not occur.

A policy titled "Monitoring of Clients and Their Services," dated July 16, 2019, indicated the licensee RN will identify vulnerabilities and risks that could pose risk to a client or to other vulnerable adults. The RN would identify

Minnesota Department of Health

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0 810	Continued From page 7 interventions to address the risks. In addition, any changes would be documented in the clients record and would be communicated to staff. A policy titled "Abuse Prevention." dated December 16, 2019, indicated each client would have an individualized abuse prevention plan that was implemented at the time of admission and updated with any changes. The nurse would identify client vulnerabilities and document an intervention that could be followed to prevent adverse events, abuse, or neglect. TIME PERIOD OF CORRECTION: Seven (7) Days	0 810		