DEPARTMENT OF HEALTH

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL27377026M **Date Concluded:** September 22, 2021
Compliance #: HL27377027C

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 **Evaluator's Name:** Jennifer Segal RN, BSN
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 staff neglected to supervise the client when the staff left the client alone in the bathroom. The client fell and sustained a spinal injury and required surgery.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility determined the client was a high fall risk and was unable to recognize or protect himself from health and safety risks and unable to seek assistance when ill or injured. The client required assistance of staff for toileting and transfers due to blindness. The client's behavior needs were not addressed by lack of communication with unlicensed staff and nurse assessment.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted other members of the clients care team outside of the facility. The investigation included a facility tour with additional time actively observing the men's memory care unit. A review of facility documents included

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client medical records, facility policies and procedures, incident reports, personnel records, and staff training records.

The client received comprehensive home care services in the men's memory unit for diagnoses that included intellectual disability, glaucoma, legally blind, seizures, depression, anxiety, delusional disorder, and obsessive-compulsive personality disorder. The service plan indicated the client received supervision and assistance with all personal cares including toileting, transferring, ambulating, dressing, escorts to all meals and activities. Also indicated reassurance or safety checks every two hours during each twenty-four-hour period.

The client's nursing assessment indicated he did not recognize or protect himself from health or safety risks and unable to seek assistance when ill or injured. In addition, he had impaired short- and long-term memory and had impaired decision making. His fall risk assessment indicated a score of 10 or higher was a high fall risk. The client's total score was 26. The assessment indicated the contributing areas of risk included intermittent confusion, history of falls, ambulatory, incontinence, and the client was legally blind.

The client's county waiver assessment indicated that the client required assistance with all cares including toileting, mobility, and dressing. The waiver provided payment to the facility for those services. The assessment also indicated the client had cognitive and psychological impairments that required twenty-four-hour supervision.

The client's progress notes indicated the client displayed impulsive behavior while waiting for assistance and had two falls that required help from 2-3 staff to lift him up.

The client nurse's notes indicated one morning, unlicensed personnel (ULP) assisted the client to the bathroom and left the client sitting on the toilet while the ULP left the room. Upon returning to the client's room the ULP found the client lying on the floor in the bathroom. The nurses note indicated two ULPs attempted to stand client up from the floor, but the client was unable to stand and stated, "my legs feel numb." The ULP reported to the nurse there were no apparent injuries and said she thought "its behavioral and not actual." The nurse directed the ULP not to move the client and call 911. The client transported to the hospital. The following day, the nurse called the hospital for report. The nurse indicated the client has a spinal cord injury and pending surgery. Four days later, a hospital updated indicated the client was paralyzed from the waist down and in the intensive care unit. One week later, the client would transfered to a transitional care unit.

Ten weeks following the incident, the client's progress note indicated the client returned to the facility. The client paraplegic (partial or complete loss of lower extremities) required a mechanical total body lift and 2 staff members for all care and mobility. The client admitted to hospice services and later died at the facility.

During an interview with the director of nursing (DON), she indicated she was just beginning employment when the incident occurred and was not involved until weeks after the incident. She indicated retraining was done with staff following the incident.

During an interview with the house manager (HM) she indicated the client was not to be left alone on the toilet.

During an interview with the nurse that was on call the morning of the incident and the following business day, indicated there was not a registered nurse (RN) to consult with the day of the fall and the following days after. She indicated the facility did not have a consistent RN, there was high turnover of nurses and she was limited with what she was able to do within her scope of practice. She described daily challenges without an RN.

During interviews with ULPs, they was reported ULPs trained other ULPs and there was not a consistent RN to direct the ULPs. One ULP stated that she was trained by another ULP that the client "faked" his abilities, he liked attention and often acted like he could not do tasks when he could. All three ULPs reported different experiences in leaving the client alone on the toilet. When asked if the client could pull the cord for assistance each ULP indicated it varied. Sometimes the client would pull the cord, other times the client would holler for help and sometimes the client got up by himself.

The client's record lacked an RN assessment of the client's behaviors and interventions to be implemented by the ULP staff.

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: Attempted, unable to participate.
Family/Responsible Party interviewed: No family.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff called 911 after the fall and had the client transported to the hospital.

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:
Dakota County Attorney
Inver Grove Heights City Attorney
Inver Grove Heights Police Department
The Minnesota Board of Nursing
The Office of Ombudsman for Long-Term Care

Minnesota Department of Health

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	H27377	A. BUILDING: ___ B. WING ___	C 08/05/2020

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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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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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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.

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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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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

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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		