Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL28352047M **Date Concluded:** September 14, 2021

Name, Address, and County of Licensee Investigated:
Ebenezer Management Services I
The Pillars of Highland Park
1925 Norfolk Ave
Saint Paul, MN 55116
Ramsey County

Facility Type: Home Care Provider **Evaluator's Name:** Danyell Eccleston, RN, Special Investigator

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 Alleged Perpetrator (AP), staff member, neglected the resident when she did not provide cares, give medications, or check on the resident during the morning shift despite the resident having scheduled morning medication and cares. When a different staff member interacted with the resident in the afternoon, the resident's physical state required emergency intervention.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP and facility are responsible for the maltreatment. The AP failed to provide cares and/or assistance to the resident during the morning hours of her shift despite the client having scheduled medications and cares. In addition, the resident was not provided care and/ or assistance the previous night with repositioning despite staff instruction to do so.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included review of the residents' medical record, facility's internal investigation file, facility policies, and employee records.

The resident admitted to the facility with diagnoses including cancer, incontinence, and compression fractures. Review of the resident's service agreement indicated he received assistance with COVID-9 screening, dressing and grooming cares, repositioning, showering, cutting up of meals, vital sign monitoring, and medication management. The resident required a mechanical lift and two staff assist to get out of bed and had an open wound to his backside.

During a weekend morning shift, the AP was assigned to care for the resident. The AP attempted to contact other staff members for assistance with getting the resident out of bed via the walkie-talkie, however, other staff members were not available at those times. Rather than enter the resident's room to let him know that cares were going to be delayed, attempt to complete cares that did not require additional staff member assistance, or push the resident's call button for continuous notification to other staff members that assistance was needed; the AP did not enter the resident's room at any time. In the afternoon when a different staff member entered the resident's room to start cares, it had been over fifteen hours since a staff member last documented repositioning or toileting the resident.

The resident's medical record indicated a member of leadership documented repositioning cares that were scheduled approximately fifteen hours before the time in question, however, the leadership member was not working per the facility schedule and no paper documentation of cares was present that would indicate the leadership member was documenting on behalf of another staff member.

The residents medical record indicated the morning of the incident the AP documented medications and cares for the resident as "Tenant resting and not going to wake up".
The AP documented she was unable to get the resident to get out of bed due to needing assistance and other staff members told her they were unavailable to assist.

During an interview with the AP, she stated she did not go into the resident's room and provide cares to the resident because she couldn't find another staff to assist with transferring the resident using the mechanical lift.

During interview the facility registered nurse stated she was called to the resident's room in the afternoon by a staff member to assist with getting the resident out of bed. When the nurse arrived at the room, the resident was incoherent, congested, and was making gurgling sounds. The nurse contacted emergency services and the resident was taken to the hospital.

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, resident deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: Internal investigation and education of staff members

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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
Ramsey County Attorney
Saint Paul City Attorney for city where incident occurred
Saint Paul Police Department
Minnesota Department of Human Services - Licensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28352	A. BUILDING: _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER MANAGEMENT SERVICES, INC	2722 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HL28352047M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #HL28352047M, tag identification 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. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by. " Following the investigators ' 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/RULES.	
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 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	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28352	A. BUILDING: _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER MANAGEMENT SERVICES, INC	2722 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one clients (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On September 14, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and an individual staff person were 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 (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	