Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL28789060M
Compliance #: HL28789061C

Date Concluded: November 10, 2020

Name, Address, and County of Licensee Investigated:
Ebenezer Home Care
7505 Metro Boulevard, #100
Edina, MN 55439
Hennepin County

Name, Address, and County of Housing with Services location:
Havenwood of Richfield
245 West 76th Street
Richfield, MN 55423
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
Michele R. Larson, 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 facility neglected the client when facility staff failed to perform scheduled safety checks, toileting, and dressing assistance. The client suffered a stroke, fell and was hospitalized.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrator (AP #1) and the facility were responsible for the maltreatment. AP #1 did not perform the any of the client's scheduled safety checks and care services during her night shift. After five days of suspension, AP #1 returned to work after minimal retraining and no supervision during her shift.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included interview with a family member. The investigation included review of the client's medical record, facility's internal investigation, facility policies, the AP and other staff personnel files.

The client's diagnoses included dementia and recurrent falls. The client lived in a secure memory care unit and received comprehensive home care services. The client's service plan included assistance with medication administration, toileting assistance, dressing assistance and escorts. The client's services included scheduled safety checks day and night. The client used a walker for mobility.

The facility investigation indicated video camera footage saw the client missed scheduled service checks between 7:00 p.m. and 7:40 a.m., during the evening and overnight shift. The evening unlicensed staff (AP #2) failed to provide toileting assistance to the client at 7:00 p.m. and 9:00 p.m. and failed to provide dressing assistance at 8:00 p.m.

At 11:25 p.m., the camera footage observed the client peeked her head out of her apartment door after midnight, but did not show the client again after that time. The overnight unlicensed staff (AP #1) failed to provide safety checks at 12:00 a.m., 2:00 a.m. and 4:00 a.m. AP #1 also failed to provide toileting assistance at 1:00 a.m. and 5:00 a.m. and dressing assistance at 6:05 a.m.

At 7:40 a.m., the morning unlicensed staff member went to the client's room to give the client her morning medication. When the unlicensed staff member walked into the client's room, she discovered the client on the floor. The client's walker was on top of the client. The client attempted to speak, but only mumbled. Unlicensed staff called the on-call nurse who instructed staff to call 911. Staff sent the client to the hospital where she was diagnosed with a stroke. Immediately following the incident, management suspended AP #2 and AP #1 while the facility conducted an internal investigation. After a few days, AP #1 and AP #2 returned to work unsupervised. The facility retrained AP #1 on falls, medication administration, universal lifts, hand washing, drug and alcohol use, and client care plans.

During an interview with AP #2, she stated during the evening shift when she worked the medication cart, she found another client with an incontinent bowel movement accident. She said due to the time it took to clean the other client she became behind in her cares. AP #2 said when AP #1 started her overnight shift she asked AP #1 to do service checks on all the clients since she had to work an overnight shift herself in another unit. AP #2 said AP #1 came back and said she checked on all the clients and reported they were all okay. AP #2 said the facility never retrained her after returning to work.

During an interview, AP #1 said she took responsibility for not checking on the client, but said other unlicensed staff told her the client was independent and required no checks. AP #1 said because she worked the overnight shift she did not know the client's care plan because most of them slept during the night. AP #1 said she signed a paper after retraining indicating to she would perform checks on the clients every hour.

During an interview, the nurse said the client had frequent safety checks and was able to express her needs. The nurse said the facility determined the client had laid on the floor for a

long time and although AP #1 performed checks with other clients, she failed to check on the client during her shift.

During an interview, the family member said the client's short-term memory had declined since her stroke. The family member said after the client hospitalization, the client was transferred to a rehabilitation center. She received speech therapy and relearned how to use her walker.

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.
(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 was an inpatient at a stroke rehabilitation center.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended both AP #1 and AP #2 during the internal investigation. The facility retrained AP #1 before returning to work.

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 parties 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
The Hennepin County Attorney
The Richfield City Attorney
The Richfield Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28789	A. BUILDING: _____ B. WING _____	C 09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER HOME CARE	2722 PARK AVE 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 ******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 September 23, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL28789061C/#HL28789060M. At the time of the survey, there were 48 clients receiving services under the comprehensive license. The following correction order orders are issued for #HL28789061C/#HL28789060M, tag identification 325, 865 and 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)	
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	0 325		

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0 325	Continued From page 1 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 one of one client (C1) was free from maltreatment. C1 was neglected. Findings include: On November 10, 2020, 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 is required for tag 0325, please refer to the public maltreatment report for details.	
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	0 865		

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0 865	Continued From page 2 home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview an document review, the licensee failed to ensure one of one client (C1) reviewed, received the required safety checks as indicated in her service plan. C1 went to the hospital and diagnosed with a stroke. 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).	0 865		

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0 865	Continued From page 3 Findings Include: C1's medical chart was reviewed. C1's medical diagnoses included but were not limited to dementia and recurrent falls. C1's service plan signed August 13, 2020 by director of health services (DHS)-D, indicated C1 required assistance with medication administration and personal cares. C1 received scheduled safety checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., and 2:05 p.m. C1 received scheduled toileting assistance at 7:00 a.m., 11:00 a.m., 1:00 p.m., 4:00 p.m., 7:00 p.m., 9:00 p.m., 1:00 a.m., and 5:00 a.m. C1 received scheduled homemaker, shower, dressing, grooming, and laundry assistance at 6:05 a.m. daily. C1 ambulated using a walker. C1's Vulnerability Safety and Risk Assessment dated March 17, 2020, indicated C1 was assessed as vulnerable in orientation to person, place and time with needed interventions provided reminders, reoriented, and redirected. C1 was assessed as vulnerable in giving accurate information consistently with the needed intervention staff and family reoriented and redirected as needed. C1 was assessed as vulnerable to endurance and strength limitations with needed interventions provided scheduled assistance to ensure needs were met. C1 was assessed as vulnerable with ambulating safely with or without assistive devices with the needed intervention required use of walker with staff reminders to use as needed. C1 was assessed as vulnerable to chronic conditions and pain with needed intervention staff provided scheduled assistance as needed to ensure needs were met. C1 was assessed as vulnerable to not following directions consistently with needed interventions family and staff redirected and reoriented as	0 865		

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0 865	Continued From page 4 needed. C1 was assessed as vulnerable to not being able to report abuse or neglect with needed intervention staff were trained on signs, symptoms, and reporting abuse and neglect. C1 was assessed as vulnerable to keeping a safe and clean environment with needed intervention housekeeping and laundry services were scheduled. C1's assessment dated March 17, 2020, indicated. The assessment indicated C1 required visual checks every two hours throughout the night and assistance of one staff with transfers and mobility. C1's progress note dated September 4, 2020, at 7:57 a.m., indicated an unlicensed personnel (ULP)-A found C1 on the floor near her bed. C1 mumbled, but was unable to speak. An on-call registered nurse (RN) instructed ULP to call 911. C1 was transferred to a local hospital. Review of the licensee camera footage report, undated, indicated Friday, September 4, 2020, unnamed staff found C1 unresponsive on the floor in her apartment. C1's walker was on top of her. The report indicated administrative staff reviewed the timeline of the evening, overnight, and morning shifts. C1 missed the following scheduled services September 3, 2020 and September 4, 2020: 7:00 p.m.- C1's scheduled toileting missed. 8:00 p.m.- C1's dressing missed. 9:00 p.m.- C1's toileting missed. 11:25 p.m.-C1 peeked out from behind her door. 12:00 a.m.-C1's safety check missed. 1:00 a.m. - C1's toileting missed. 2:00 a.m. - C1's safety check missed. 4:00 a.m. - C1's safety check missed. 5:00 a.m. - C1's toileting missed.	0 865		

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0 865	Continued From page 5 6:05 a.m. - C1's dressing missed. 7:00 a.m. - C1's toileting missed. 7:40 a.m. - C1 found on floor. The report indicated staff who worked those shifts were suspended during an internal investigation. The internal investigation was conducted over a few days and consisted of review of camera footage, witness statements, and an incident report. Review of ULP-F's September 3, 2020 schedule, indicated ULP-F clocked in at 9:58 p.m. for overnight shift and clocked out at 6:32 a.m. on September 4, 2020. Review of ULP-A's September 4, 2020 schedule, indicated ULP-A clocked in at 6:05 a.m. for morning shift and clocked out at 2:26 p.m. on September 4, 2020. Review of ULP-A's witness statement dated September 4, 2020 at 10:00 a.m., indicated ULP-A entered C1's room at 7:39 a.m. and found C1 on the floor. ULP-A immediately called ULP-C for assistance. C1 responded to verbal commands. ULP-A called 911. C1 was transported to a local hospital. ULP-A reported on September 3, 2020 at 2:00 p.m. was the last time she saw C1 at her baseline. Review of the licensee's incident report completed on September 7, 2020, at 9:45 a.m., by licensed practical nurse (LPN)-B, indicated ULP-A, discovered C1 on the floor with her walker on top of her. C1's head leaned against a wall. C1's vital signs were noted; blood pressure 178/95, pulse 86, oxygen saturation (O2) 97%, temperature 97.6 Fahrenheit, and respirations 22. Review of C1's progress noted dated September	0 865		

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0 865	Continued From page 6 4, 2020, at 5:12 p.m., indicated C1 was transferred to the intensive care unit (ICU) at a local hospital where she was diagnosed with a stroke. The client was given antithrombolytic (blood thinner) medication while in the ICU. Review of C1's progress noted dated September 6, 2020, at 4:02 p.m., indicated C1 was transferred from ICU to a stroke rehabilitation center. C1's speech was garbled and right-sided paresis and right facial droop. C1's was placed on a honey-thickened diet. C1 remained in the stroke rehabilitation center at the time of the onsite investigation. During an interview on September 23, 2020, at 11:09 a.m., ULP-A said at the beginning of the morning shift she and the overnight ULP would go and check on the clients together. ULP-A said the morning of C1's incident they never checked on the clients. ULP-A stated, "I asked her if she did rounds and she said yes, everyone's good. That was my mistake. I trusted her." ULP-A said she walked down to C1's room to giver C1 her medication and found C1 on the floor, lying face up with her eyes open. ULP-A said she called the nurse right away and filled out an incident report. ULP-A said staff had retraining on safety and care plans. During an interview on September 23, 2020 at 2:00 p.m., DHS-D said C1 required basic cares and cueing. DHS-D said C1 expressed her needs and used a call pendant when she needed help. DHS-D said staff performed frequent safety checks on C1, stating C1's gait was unsteady. DHS-D said LPN-B collected statements from staff who worked the shifts. DHS-D said the administrator and LPN-B viewed video camera footage from the overnight shift and noted ULP-E	0 865		

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0 865	Continued From page 7 never entered or checked on C1, but checked on other clients. DHS-D said checks were not performed on C1 until 7:40 a.m., when ULP-A entered C1's room. said outgoing and incoming staff were required to check on clients before outgoing staff's shift ends. DHS-D said she was told by ULP-A and ULP-C the office was dark when they arrived to work the morning shift. RN-A said when they opened the office door, ULP-F jumped up from a chair, appearing sleepy. DHS-D said it was unusual, but said lights were automatic and was unsure of the time it took for the lights to turn on. DHS-D said ULP-A, ULP-F, and the evening ULP were suspended during the investigation; but returned to work after receiving retraining on licensee's policies on fall protocol, documentation, and following client's care plans. During an interview on October 7, 2020, at 11:05 a.m., ULP-F said she worked 10:00 p.m. until 6:30 a.m.. ULP-F said she charted on her work phone where she viewed client's care plans and required hourly checks. ULP-F said their work phones contained checklists for clients indicating checks that needed to be completed during each shift. ULP-F said when she arrived to work the overnight shift on September 3, 2020, she checked on clients except for C1. ULP-F said she was told by other staff C1's door was always locked and C1 did not need to be checked. ULP-F stated, "oh, I thought she was an independent person. I was trained on her care plans. I don't know why I thought she was independent." ULP-F said some clients required changing at 5:00 a.m., but not C1, stating, "I don't think C1 needed toileting. I don't really know a lot about the clients. I really don't get to see their cares. I just come in and they're sleeping all night. I take them to the bathroom and then get them back to bed." ULP-F said when management told	0 865		

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0 865	Continued From page 8 her about C1's hospitalization she blamed herself. ULP-F said she returned to work after retraining on care plans, documentation, and fall protocol. The licensee position description for "Resident Assistant", (ULP), dated June 2017, indicated ULP's followed client's care plans to meet client's needs. ULP's responded to client's needs in a timely and courteous manner and treated clients with dignity and respect. The licensee policy titled Service Plan Agreement Form, updated November 15, 2019, indicated the client's service plan included description of home care services provided, and the frequency of each service according to the client's current assessment and preferences. The policy indicated the licensee would provide all services required by the current service plan agreement. Staff providing home care services were informed of the services on the client's written service plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 865		
01252 SS=D	144A.4798, Subd. 3 Infection Control Program Subd. 3.Infection control program. A home care provider must establish and maintain an effective 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 and document review the licensee failed to maintain an effective infection	01252		

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01252	Continued From page 9 control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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). Findings Include: Visitor Screening The licensee failed to actively screen visitors, including surveyors, for temperature and symptoms of COVID-19 prior to entering the facility. The Minnesota Department of Health's (MDH) "COVID-19 Toolkit: Information for Long-Term Care Facilities," dated August 14, 2020, indicated congregate care settings should actively conduct health screening for essential health care personnel including state surveyors. Active screening meant a trained person should physically monitor temperature, and ask questions regarding COVID-related symptoms when people enter the building. On September 23, 2020, at 9:15 a.m., the surveyors entered the licensee. No staff were observed at the front desk. Staff were observed walking out of a conference room in sight of where the surveyors were standing. Staff failed to take the surveyors' temperatures or ask COVID-19 screening questions.	01252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28789	A. BUILDING: _____ B. WING _____	C 09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER HOME CARE	2722 PARK AVE SOUTH MINNEAPOLIS, MN 55407

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01252	Continued From page 10 On September 23, 2020, at 9:20 a.m., the director of health services, (DHS)-D, approached the surveyors and walked them back to a conference room. Staff failed to take the surveyors' temperatures or ask COVID-19 screening questions. The investigators had no temperatures obtained or asked COVID-19 screening questions. During an interview on September 23, 2020, at 9:48 a.m., a staff member was seated at the reception desk. The staff member said she worked the front desk until 5:00 p.m. and when visitors checked in they received a visitor's badge, and had their temperature checked and logged on the visitor sign-in sheet. The licensee policy titled "Visitation Modifications During COVID-19 Pandemic-Implementation of Reopening," dated August 26, 2020, indicated all visitors who entered the licensee would be actively screened for signs and symptoms of COVID-19 prior to walking into the licensee. Screening consisted of having temperature taken and COVID-19 screening questions asked. TIME PERIOD FOR CORRECTION: Two (2) days.	01252		