MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Alliance Home Health Care

Facility Address:
5701 Shingle Creek Parkway #631

Facility City:
Brooklyn Center

State:	ZIP:	County:
Minnesota	55430	Hennepin

Report Number:
HL30405001

Date of Visit:
April 24 and 25, 2017

Time of Visit:
11:45 a.m. to 4:15 p.m and 8:15 a.m. to 3:30 p.m.

Date Concluded:
July 7, 2017

Investigator's Name and Title:
Casey DeVries, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It was alleged a client was financially exploited and was not provided adequate nursing care by unnamed but multiple staff/alleged perpetrators. Client expired on Thursday and staff did not realize that client had died until Monday, and then 911 was notified.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect is substantiated. Multiple staff failed to respond to a client's declining condition by notifying the client's primary care provider, calling for emergency medical services (EMS), or providing life-sustaining treatment. The client expired in the client's home without receiving any health care intervention, although the client's code status indicated resuscitation should have been attempted.

Based on a preponderance of evidence, financial exploitation is not substantiated. The complaint indicated the home care provider falsified hours worked for the client and fraudulently billed based on a falsification. However, the investigation did not identify any instances of documentation that staff were present with the client, when they were actually not present.

The client received services from the licensed comprehensive home care provider. The client's diagnoses included chronic respiratory failure requiring continuous ventilator support, diabetes, stroke history, and heart failure. The client received services including dressing, grooming, bathing, incontinence care, transfers, mobility, nutrition via tube feeding, ventilator management, and medication administration. The

client's care plan indicated the client's code status was full code, meaning the client desired emergency care, including cardiopulmonary resuscitation, if needed.

Three licensed nurses worked with the client over the four day period prior to the client's death. Alleged Perpetrator #1 (AP#1) worked day one for twelve hours. Another nurse worked day one for the other twelve hours. AP#2 worked day two for twenty four hours. AP#1 worked again days three and four, for the remaining thirty hours.

Based on document review, the client had been recently prescribed an antibiotic for a urinary tract infection. On day one, the client was showing symptoms including a fever, increased heart rate, and increased blood pressure. AP#1, who worked the day shift on day one, did not notify the primary care provider of the client's condition.

During the night shift on day one, the other nurse noted the client's symptoms, including on-going fever, thick greenish colored secretions, a heart rate of 200, and an oxygen saturation level of zero. The nurse began administering CPR and called 911. The client was stabilized by EMS in the home and was not transported to the hospital.

On day two, the client had increased oxygen demand, cold extremities, low body temperature, low blood sugar, and a faint pulse. AP#2 stated an attempt was made to contact the client's primary care provider, but AP#2 was unable to reach anyone and did not follow up. The client's ventilator later began alarming. AP#2 called the medical supply company for assistance. During trouble-shooting of the ventilator issues, AP#2 was informed by the medical supply company's on-call respiratory therapist that the issue causing the alarm was likely with the client, not the ventilator. AP#2 did not make additional attempts to contact the client's primary care provider or call for emergency medical care.

On days three and four, the client was cared for by AP#1. At the start of the shift on day three, AP#1 documented the client was unresponsive with no pulse. AP#1 did not attempt to provide life-sustaining treatment, call 911, or contact the client's primary care provider. AP#1 continued to work in the home over the next thirty hours without documenting a comprehensive assessment of the client, implementing any new interventions, or requesting assistance. On the morning of day four, the family contacted a funeral home, and the funeral home picked up the client's body.

AP#1 stated, during an interview, that s/he had been anticipating a call from the client's nurse practitioner on day one, for follow up regarding the client's previous infection. AP#1 said s/he would have notified the nurse practitioner at that time of the on-going symptoms if a call had been received; however, AP#1 stated s/he did not place a call to update the nurse practitioner, because the client did not appear to be in obvious distress. AP#1 stated the client was stable because the client had recently been on an antibiotic and because the client's fever was being controlled with over-the-counter medication. AP#1 denied documenting the client's abnormal vital signs which appeared in the medical record for day one, and said an increased heart rate and increased blood pressure would have been concerning to him/her.

During an interview, the other nurse stated s/he had 911 called towards the end of his/her twelve hour shift

on day one. S/he reported to the on-coming nurse (AP#2) and requested AP#2 update the nurse practitioner about the client's condition and about the incident requiring emergency medical services.

During an interview, AP#2 stated, on day two, attempts were made to contact the nurse practitioner and physician to follow up regarding the client's previous infection. AP#2 stated s/he was unable to leave messages because the phones were not answered. AP#2 stated s/he found it concerning the client was requiring more oxygen than normal to maintain oxygen saturation. AP#2 stated the client's vital signs kept going "back and forth" and s/he recalled re-checking the client's blood sugar and thought it had come up. AP#2 stated the nurse practitioner would have been updated of the client's status had s/he been able to reach him/her. AP#2 stated s/he had wanted to call 911 and send the client to the hospital, but the client's family member was resistive to calling 911. AP#2 stated the family member told AP#2 that the client was on comfort care now, although AP#2 was unable to verify an order had been given for comfort care. AP#2 stated that later during his/her shift, the client's ventilator began alarming and after about five to ten minutes of trying to trouble shoot the problem, AP#2 called the medical supply company for help. AP#2 stated after some additional trouble shooting, the alarm stopped and did not sound again for the remainder of the shift. AP#2 was unable to recall the last time s/he checked for a pulse on the client.

Also during the interview, AP#1 stated that on day three s/he received report from AP#2 that the client was on comfort care. AP#1 stated s/he knew the client's code status had been full code and that the previous nurse was unable to verify any order for comfort care. AP#1 stated s/he mistakenly wrote in the progress note that the client had no pulse, but meant to write the client had a "fainting" pulse at the start of the shift. AP#1 explained "fainting" pulse as meaning s/he took the pulse manually and it seemed to be there but was "not bounding or active." AP#1 further stated the client's pulse was "fading away" and that "it's like you don't feel nothing." AP#1 stated the client did not open his/her eyes and appeared to be sleeping. AP#1 was unable to say if the client was still alive at that time, stating it was not his/her scope to say if the client died. AP#1 said because the ventilator was still causing the client's chest to rise and fell, s/he could not verify death, stating someone could have a low pulse or no pulse and still be alive. AP#1 stated she knew there was something wrong with the client, but the client's family member would not let the AP#1 use the phone to call 911, the primary care provider, or a supervisor. AP#1 stated the family member also would not allow CPR to be initiated.

During an interview, the client's family member stated nursing did not make him/her aware of the severity of the client's condition during days two and three. The family member denied telling AP#1 or AP#2 not to call 911. The family member stated the client was full code and there was never any discussion pertaining to comfort care with the client's primary care providers or in-home nurses. The family member said that since the client was recently in the emergency room for an infection and had also been examined by the nurse practitioner, s/he was under the impression the client just needed to rest and recover. The family member stated she relied on the nurses to keep him/her informed.

An interview with a member of management staff revealed s/he was aware the client's code status was full code. S/he stated no order was received for comfort care for the client. S/he was aware an attempt was made to contact the primary care provider on day two without response, and that AP#2 had wanted to send the client to the hospital. AP#2 did not alert him/her about the severity of the client's vital signs, blood

sugars, or the family member's resistance to calling EMS. S/he stated s/he was under the impression AP#2 had left a message with the primary care provider's office, not that the phone was never answered. S/he indicated s/he was aware AP#2 placed a call to the ventilator supply company for trouble-shooting assistance, so s/he told AP#2 to try calling the client's primary care provider again and wait for the ventilator supply company to call back.

An interview with the client's primary care provider, a nurse practitioner (NP), revealed s/he was not made aware of the client's declining condition over days two, three, or four. NP stated the client's family member never gave the him/her any indication of wanting anything other than aggressive therapy for the client, and a change of code status was never discussed or ordered. NP added s/he would have given orders to send the client to the hospital immediately had s/he been updated accordingly, and the client likely would have had a different outcome if sent to the hospital for treatment.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

The allegation of financial exploitation is not substantiated.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Alleged perpetrator #1 (AP#1) is responsible for the neglect because s/he knew the client's code status had been full code and that the previous nurse was unable to verify any order for comfort care, but did not attempt to provide life-sustaining treatment, call 911, or contact the client's primary care provider although s/he documented the client was unresponsive and had no pulse or a faint pulse.

AP#2 is also responsible for the neglect because although s/he was aware of the client's increased oxygen demand and decreased blood glucose and body temperature, and although s/he had concluded the client required emergency medical services and hospitalization, AP#2 did not attempt to call 911 or contact a supervisor, did not continue to try to reach the client's primary care provider, and did not implement any new interventions.

The facility is responsible for the neglect because the facility failed to ensure that the nurses providing care to the client provided indicated emergency treatment, contacted the client's primary care provider, or called emergency medical services when the client had increased oxygen demand, abnormal vital signs, and decreased responsiveness.

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.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records
- [x] Ambulance/Paramedics
- [x] Medical Examiner Records
- [x] Death Certificate
- [x] Police Report
- [x] Other, specify:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: None

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Resident deceased.

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ○ Yes ○ No ◉ N/A

Specify: Anonymous reporter

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: None

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ◉ Yes ○ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☒ Emergency Personnel ☒ Police Officers ☒ Medical Examiner ☒ Other: Specify _____

Observations were conducted related to:

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Hennepin County Medical Examiners

Brooklyn Center Police Department

Hennepin County Attorney

Brooklyn Center City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H30405	A. BUILDING: _____ B. WING _____	C 05/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH CARE INC	5701 SHINGLE CREEK PKWY #631 BROOKLYN CENTER, MN 55430

(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, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On April 24, 2017, a complaint investigation was conducted to investigate complaint #HL30405001. At the time of the survey, there were nine clients receiving services under the comprehensive license. The following correction orders are issued.	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 subd. 11 (b) (1) and (2).	
0 315 SS=K	144A.44, Subd. 1(12) Served by People Who Are Competent Subdivision 1. Statement of rights. A person who	0 315		

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0 315	Continued From page 1 receives home care services has these rights: (12) the right to be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that staff were trained and competent when, over the course of four days, staff failed to notify the client's primary care provider or provide emergency care during a significant change of condition for one of one client (C1) reviewed. The client, who was ventilator-dependent, had decreases in oxygen saturation, body temperature, and blood glucose level, and then had no pulse. The client died, and the death was not documented. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and is 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: Medical record review indicated C1 was admitted with diagnoses that included chronic respiratory failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. C1's care plan, dated 12/20/2016, indicated C1's code status was full code, meaning resuscitation should be attempted.	0 315		

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0 315	Continued From page 2 A nursing progress note dated 1/25/2017, for the 7:00 a.m. to 7:00 p.m. shift, indicated C1's Nurse Practitioner (NP)-F was contacted due to C1 having an increased temperature, drooling, and drowsiness. NP-F ordered C1 be sent to the hospital for further evaluation. Review of a hospital discharge summary, dated 1/25/2017, indicated C1 was sent to the hospital, diagnosed with a urinary tract infection, prescribed an antibiotic, and was sent back home the same day. A progress note dated 1/27/2017, written by Registered Nurse (RN)-D for the 7:00 a.m. to 7:00 p.m. shift, indicated a call was received from the hospital to discontinue the previously prescribed antibiotic, and that the Nurse Practitioner would call back with new orders, if necessary. C1's ventilator flow sheet, dated 1/27/2017, written by RN-D, indicated C1's vital signs at 8:00 a.m. on 1/27/17 were temperature 99.1, heart rate 105, and blood pressure 181/108. A progress note dated 1/27/17, written by Licensed Practical Nurse (LPN)-E for the 7:00 p.m. to 7:00 a.m. shift indicated the initial assessment of C1 included temperature 99.8, heart rate 70, blood pressure 184/76, oxygen saturation level of 95%, and thick greenish color secretions were noted. At 1:00 a.m., C1's heart rate was greater than 200 and C1's oxygen saturation was zero (normal was greater than 90%). The note indicates LPN-E then administered cardiopulmonary resuscitation (CPR) to C1 and called emergency medical services (EMS). Review of the ambulance service record dated 1/28/2017 indicated EMS dispatched to C1's	0 315		

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0 315	Continued From page 3 location for a report of cardiac arrest, not breathing. The record indicated the chief complaint upon arrival was breathing problem, but that C1 was breathing regularly without difficulty. C1 had strong bilateral radial pulses with an oxygen saturation level of 99%. The report narrative indicated FM-G informed EMS that C1 had a recent head cold and urinary tract infection, and had been in the hospital where C1 was prescribed an antibiotic for the infection. The report indicated Family Member (FM)-G called EMS because C1 was having a hard time breathing and because C1's skin color was very poor. FM-G signed a refusal to go to the hospital, and was advised to continue the antibiotic medication as prescribed by physician and to call 911 back if anything changed or worsened. A progress note dated 1/28/17, written by RN-C for the 7:00 a.m. to 7:00 p.m. shift and for the 7:00 p.m. to 7:00 a.m. shift, indicated C1 now required five liters of oxygen to maintain an oxygen saturation level of 90%, and that C1's feet were cold to the touch. RN-C placed calls to two pharmacies to check for a new antibiotic order, then attempted to reach C1's primary care providers but was placed on hold and did not reach anyone. RN-C was attempting to contact an unknown nurse practitioner, and a medical doctor who was not C1's primary and who was not on C1's face sheet. The note further indicated RN-C wanted to call EMS at 12:00 p.m., but FM-G refused. RN-C called the ventilator company around 1:00 p.m. for trouble shooting assistance when the ventilator began alarming. C1's pulse was faint when checked manually. C1's medication administration record for 1/28/17 indicated C1's blood glucose levels were checked at 8:00 a.m. with a result of 50 mg/dL, and at 8:00 p.m. with a result of 26 mg/dL. C1's ventilator flow	0 315		

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0 315	Continued From page 4 sheet indicated C1's body temperature had dropped from 98.3 at 8:00 a.m. to 94.0 at 3:00 p.m. and C1's oxygen saturation level continued to drop to 82% at 3:00 p.m. and 0% at 9:00 p.m. Review of a ventilator supplier note dated 1/30/2017 indicated a call was received on 1/28/17 at 11:00 a.m. from nursing, stating that the bedside ventilator was alarming with the message "check circuit." The note indicated the person who took the call assisted the nurse with trouble-shooting the alarm, including switching the client to the back-up ventilator. The note indicated the back-up ventilator alarmed also. The note stated "Nurse swapped out the circuit on the bedside vent and hooked up to the test lung. Vent is performing as it should. When pt is placed back on vent alarm continues Low Ve. Let nurse know that it is likely an issue with the patient. Nursing checked her cuff and inflated it some more. This did not fix the problem. I wonder if the cuff is not [sic] longer holding air? Nursing will check this. They will call me back if anything else is needed." The note also stated "Let them know to call 911 with an emergency." A progress note dated 1/29/17, written by RN-D for the 7:00 a.m. to 7:00 p.m. shift indicated that at the beginning of the shift, the client was unresponsive and there was no pulse reading. C1 did not have any bowel or urinary movement throughout the shift and the tube feeding and water flush was still infusing. RN-D wrote, "Vent machine working and assisting client to breathe" and "Staff would continue to give comfort care." C1's medication administration record for 1/29/17 indicated RN-D documented C1's blood glucose level at 8:00 a.m. was 48 mg/dL. A progress note dated 1/29/17, written by RN-D	0 315		

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0 315	Continued From page 5 for the 7:00 p.m. to 7:00 a.m. shift indicated the client continued to be unresponsive with no pulse. RN-D indicated FM-G was asked to call EMS because C1's body was cold to touch and C1 remained unresponsive, but FM-G refused. The note indicates C1 had no bowel or urinary movement, "The vent machine continues to assist client with breathing," and "Staff will continue to give comfort care." A progress note dated 1/30/17, written by RN-D for the 7:00 a.m. to 1:00 p.m. time period stated C1 continued to be unresponsive, and FM-G was again notified at 7:00 a.m. of the client's status. FM-G advised RN-D not to place any calls out until family arrived. The note indicated at approximately 10:00 a.m., family members contacted a funeral home and the funeral home arrived at approximately 12:50 p.m. to pick up C1's body. During an interview on 5/15/17 at 10:00 a.m., RN-D stated she worked the 7:00 a.m. to 7:00 p.m. shift on 1/27/17. RN-D stated she took the phone call to discontinue C1's antibiotic order, although she was unable to recall from where the call originated. RN-D stated she did not believe she updated C1's primary care provider regarding the discontinuation of the antibiotic, but could not remember. RN-D was anticipating a call with a new antibiotic order and had intended to give any updates to the Nurse Practitioner at that time. RN-D stated she did not believe C1 was in any distress, and that there was no reason to contact the Nurse Practitioner. RN-D gave report to LPN-E at the end of her shift and told her C1 had been running a low-grade temperature but it was being controlled by over-the-counter medications. RN-D indicated she also informed C1's family member (FM)-G about the antibiotic being	0 315		

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	H30405	A. BUILDING: _____ B. WING _____	C 05/19/2017

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0 315	Continued From page 6 discontinued. During an interview on 5/8/17 at 11:15 a.m., LPN-E stated that during her shift, C1's oximeter began beeping, prompting LPN-E to call FM-G to the bedside where FM-G was informed of C1's tachycardia (rapid heart rate). LPN-E asked FM-G to call EMS. LPN-E stated she then manually checked C1's pulse but was unable to palpate it at all. LPN-E informed the 911 dispatcher of her finding, and the dispatcher instructed her to initiate CPR. LPN-E stated that during the course of administering CPR, C1's pulse returned, so she stopped chest compressions prior to EMS arrival. LPN-E indicated she was aware of C1's code status being full code because it was in C1's file, and because FM-G told her so. EMS asked FM-G if she wanted C1 to go to the hospital, but FM-G said the doctors were already aware of C1's status, and FM-G refused transport to the hospital that night. LPN-E did not call to update C1's primary care provider of the event, but stated she asked the on-coming day nurse to do so. LPN-E did not update the executive director, whom she considered her supervisor, of the incident. During an interview on 5/11/17 at 9:00 a.m., RN-C stated she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/28/17. RN-C was aware that EMS had been to the home in the early morning hours, but stated she was not aware that LPN-E performed CPR on C1. RN-C also denied that LPN-E asked her to update the primary care providers regarding the incident. RN-C stated she did attempt to contact the primary care provider after unsuccessfully calling two pharmacies in search of a new antibiotic order for C1. RN-C stated she	0 315		

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0 315	Continued From page 7 attempted to call the Nurse Practitioner's office, but the line to which she was transferred was not answered. The same thing happened when she tried to call the physician's office. RN-C stated that C1's oxygen saturation was at 90% on five liters of oxygen, and that this was an indicator something was wrong, because previously the client's oxygen saturation level had been 97-98% on one or two liters of oxygen. RN-C stated she documented a blood glucose level of 50 mg/dL at 8:00 a.m., and that this value was abnormally low. C1 was on a tube feeding which was running well. RN-C was unable to recall what time she re-checked the blood glucose level or what the result was. RN-C stated she had intended to update the Nurse Practitioner of the low blood glucose level if she had been able to reach her by phone. RN-C stated she informed FM-G of the current oxygen liter flow but not about the low blood glucose value. RN-C stated she recommended contacting EMS because she had not been able to obtain a new antibiotic order, was unable to reach a provider, and was concerned regarding the low oxygen saturation levels. RN-C stated FM-G declined to have C1 go to the hospital, and told RN-C that C1 was now on comfort care. RN-C stated she was unable to verify an order for comfort care, as the hospital discharge paperwork was not in C1's file. RN-C stated she would have asked the primary care providers if C1's code status was changed if she had been able to reach them. When the ventilator started beeping, RN-C tried trouble shooting it for five to ten minutes before calling the supplier for assistance. RN-C was instructed via phone to check for a small hole, to change the circuit, and to check the trach ties to make sure they were tight. She did those things and the alarm stopped. RN-C denied being told to hook up the ventilator to the test lung. The alarm did not sound again for	0 315		

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0 315	Continued From page 8 the remainder of her shift. RN-C's assessment of C1 at that time was that C1 was sick with a urinary tract infection, but she was concerned something else was also going on, due to the low oxygen saturation levels and blood glucose levels. RN-C said C1's vitals kept going "back and forth." RN-C did not recall documenting an oxygen saturation level of zero at 9:00 p.m. RN-C reiterated that she wanted the client to go to the hospital but felt that because the family member did not want the client to go, she "didn't have much to work with." RN-C did not know the last time she checked for a pulse on C1. RN-C stated she did not update the executive director, whom she considered the supervisor, regarding the C1's condition. RN-C stated she should not have taken FM-G's word that C1 was on comfort care and that she should have sent C1 to the hospital. During an interview on 5/15/17 at 10:00 a.m., RN-D stated she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/29/17, as well as from 7:00 a.m. to 1:00 p.m. on 1/30/17. RN-D stated the report from RN-C, on 1/29/17 at 7:00 a.m., was C1 was on comfort care now. RN-D stated RN-C told her she had attempted to call C1's primary care providers to verify if there was an order for comfort care but was unable to reach anyone. RN-C also told RN-D she called for assistance to trouble shoot the ventilator during her shift. RN-D assessed C1 and determined C1 had a "fainting pulse." RN-D said she was aware C1's code status was full code, which meant to do everything to keep the client alive. RN-D stated this meant that if C1 was unresponsive with no pulse, CPR should be initiated and EMS should be called. RN-D stated that when she documented C1 had no pulse and was unresponsive, she meant C1 had a "fainting pulse" and when she tried to talk to C1, C1 did	0 315		

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0 315	Continued From page 9 not open her eyes. RN-D stated she was not sure if C1 was alive, because she did not think it was in her scope to say whether the client had died. The ventilator was on and working, C1's chest was rising and falling, and the ventilator was not alarming. RN-D stated C1's skin was cold to the touch. RN-D said the protocol was to initiate CPR and call EMS in this situation. RN-D stated she attempted to call EMS, but she was unable to because she did not have access to a phone. RN-D stated FM-G had the only phone and would not allow RN-D to make an emergency call. RN-D did not use her phone to call EMS, because she had been given warnings in the past about having her personal phone in the home, so left the phone in her car. RN-D stated her nursing judgment told her to call EMS and do CPR. RN-D stated she checked C1's pulse manually at 7:00 p.m. on 1/29/17, and it was "fading away." RN-D stated the primary care providers were not contacted, throughout the thirty hours RN-D was in the home, when C1 had a documented blood glucose level of 48 mg/dL, had a faint or absent pulse, and had a decrease in body temperature and oxygen saturation. RN-D did not know when the funeral home had been contacted. RN-D said she should have insisted on calling EMS and initiating CPR. During an interview on 5/8/2017 at 10:15 a.m., Family member (FM)-G stated C1's code status was full code. FM-G stated there was no discussion pertaining to comfort care with any providers. FM-G called EMS on 1/27/17 when LPN-E told her to do so. FM-G observed LPN-E doing chest compressions on C1. FM-G told EMS that C1 had just recently been to the hospital and was given an antibiotic. FM-G stated C1 was stable at that time. FM-G also believed C1 to be stable on 1/28/17, the day the ventilator was	0 315		

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0 315	Continued From page 10 alarming, but stated she did not tell RN-C not to send C1 back to the hospital. FM-G stated she believed C1's condition had turned for the worse when she came downstairs the following morning because C1's face was gray. FM-G stated at that time she called C1's children to tell them to come see her. FM-G denied telling anyone not to call 911, and said he trusted the nurses to inform her of what was going on with C1, but they did not. During an interview on 5/11/17 at 1:10 p.m., Family Member-H (FM-H) stated the family's wishes for C1's code status was for C1 to be full code. FM-H stated the last day he saw C1 was two or three days prior to her passing away, and that C1 looked fine then. FM-H said s/he was not aware of any recent discussions about not sending C1 to the hospital anymore, or any hospice or palliative care discussions. An interview with Funeral Director-I (FD-I) on 4/26/17 at 3:40 p.m., indicated C1's body was removed from the home at 8:30 a.m. on 1/30/17. FD-I stated he received a call from a nurse early that morning, however, FD-I did not know the time or the name. FD-I stated after he spoke with the nurse, he then spoke with FM-G and FM-H over the phone. FD-I had been made aware of C1's death the evening prior when a relative of C1's called FD-I at approximately 10:00 p.m. to say C1 had died. FD-I stated he did not have anything official or legal informing him of that, so he could not confirm whether C1 had actually passed away at that time. FD-I stated that in his opinion, rigor mortis (temporary rigidity of the body after death) had already come and gone by the time C1's body was removed from the home on 1/30/17. During an interview with Nurse Practitioner	0 315		

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0 315	Continued From page 11 (NP)-F on 5/5/17 at 4:00 p.m., NP-F stated she assumed care of C1 on 12/23/16. NP-F stated she saw C1 a total of three times in the home and the last face-to-face visit was on 1/26/17, just after C1 had been seen in the Emergency Department on 1/25/17. NP-F stated C1's vital signs were stable that day, but she noted C1 had an increased heart rate of 111. C1's O2 saturation was 100% on the ventilator, with one liter of oxygen. NP-F stated C1's medical record said multiple times that she was full code, and NP-F had not discussed changing that with C1's family. NP-F stated she had not been contacted by nursing on 1/27/17 regarding on-going fevers with increased greenish secretions. NP-F stated she would have recommended C1 have another set of labs drawn, such as a white blood count, a procalcitonin, and a chest x-ray. NP-F stated she was not informed that a nurse performed CPR on C1 during the overnight hours of 1/27/17-1/28/17, and there was no note regarding it in the written record, which would indicate the clinic had not been notified. NP-F stated she would have sent the client to the hospital immediately if she had been aware CPR was administered. NP-F was not made aware on 1/28/17 of the increased oxygen demands, low blood glucose readings, or faint pulse. NP-F stated C1's hypoglycemia should have been treated with glucagon, after a re-check of C1's blood glucose to verify the number was accurate. NP-F stated she would have told staff to make sure C1 was getting her tube feeding, and to hold the insulin. NP-F was not contacted on 1/28/17 when the ventilator alarmed. NP-F stated that given the cluster of recent symptoms along with ventilator issues, she would have strongly recommended C1 be sent to the hospital. NP-F stated she believed FM-G would have wanted continued aggressive therapy for C1. NP-F stated she would have required	0 315		

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0 315	Continued From page 12 clarification from FM-G if she had wanted to change her plan of care to include end of life hospice care. NP-F was concerned the nursing staff may have been attempting to contact C1's previous providers. NP-F stated that if C1 had an infectious process going on, and had been admitted to the hospital, it likely could have been treated, producing a different outcome. During an interview on 5/9/2017 at 9:03 a.m., Director of Nursing (DON)-B indicated she was not informed by the nurse regarding C1's hospitalization on 1/25/17, rather, she was told later by ED-A that C1 had a high pulse and was admitted to the hospital. DON-B was not informed of LPN-E performing CPR on C1 until two days later, when ED-A told her. DON-B was not contacted by RN-C on 1/28/17 when C1 had blood glucose readings of 50 mg/dL and 26 mg/dL, and also was not contacted about RN-C having trouble with the ventilator or that RN-C had wanted to call EMS for C1. DON-B was not aware C1 had increased oxygen demands or a faint pulse on 1/28/17. DON-B stated she also works with clients in the home and often misses calls, but that ED-A, who is an LPN, usually gets the active calls and will update DON-B via text message. DON-B stated that if staff do not get a call back from a provider after leaving a message, staff are supposed to follow up with the provider again in a couple of hours, if still no response, DON-B or ED-A should be notified. DON-B stated she was not contacted by RN-D on 1/29/17 about C1 not having a pulse and did not learn of it until 1/30/17. DON-B stated C1's code status was full code and that full code meant to do everything to the keep the client alive and to call 911 if the client's condition required it. C1's code status was located in her chart and DON-B was unaware of any order given for C1 regarding	0 315		

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0 315	Continued From page 13 comfort care. DON-B stated if she had been informed by the nurse about FM-G declining to have C1 go to the hospital following the administration of CPR on 1/27/17, she would have discussed the decision with FM-G. DON-B stated the protocol if a full code client is found without a pulse is to start CPR and call EMS. DON-B stated RN-D should have called the physician, director of nursing, charge nurse, or the executive director regarding C1's decline. An interview with Executive Director (ED-A) on 4/25/17 at 1:09 p.m. indicated she was aware that C1's code status was full code. ED-A said there was no order given for comfort care for C1. ED-A stated she did not receive an update during the 1/27/17 shift when LPN-E administered CPR to C1. ED-A was informed the next morning that EMS was called to the home, but was told that EMS said everything was fine. ED-A said that LPN-E should have called to update a supervisor or a registered nurse that she had to give CPR to C1. ED-A spoke with RN-C on 1/28/17 when ED-A happened to call C1's home. RN-C informed her she had placed a call to the doctor's office with no response, and that RN-C had wanted to call EMS. ED-A stated she instructed RN-C to call the doctor's office again but that RN-C did not mention the blood glucose level to ED-A. RN-C informed ED-A that the ventilator had alarmed. ED-A stated the physician should have been notified and if there was no response, EMS should have been called. ED-A stated she thought the nurse on duty should have called 911. ED-A stated she received a call from RN-D at about 7:00 p.m. or 8:00 p.m. on 1/29/17. RN-D told ED-A that C1's pulse was fainting and the ventilator was working. ED-A stated that if she had been notified that C1 had no pulse, she would have instructed RN-D to call EMS. ED-A	0 315		

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0 315	Continued From page 14 stated she did not receive a call from RN-D to say she thought C1 had died. ED-A stated she expected staff to call either EMS or the physician's office, and to initiate CPR. The licensee's undated policy titled, "Cardiopulmonary Resuscitation (CPR)" indicates it is the licensee's policy to attempt CPR for all persons requiring help due to a medical emergency of cardiac and/or respiratory arrest, unless there is an established do not resuscitate (DNR) order in place. The policy further indicates that if a staff member is unsure if a DNR order exists, the CPR policy must be followed. The licensee's undated policy titled "Advance Directives" indicates on page five that if a patient or the patient's representative revokes or attempts to revoke an Advance Directive, then the patient's attending physician and the agency shall be contacted immediately and notified of the revocation or attempted revocation, and if there are any questions regarding an Advance Directive for a patient, to contact the patient's physician and the supervisor. On page six, the policy further indicates that if a dispute arises concerning an Advance Directive, then the agency shall contact the patient's physician immediately and follow the decision and orders of the patient's physician regarding the resolution of the dispute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 315		
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 15 (14) the right to 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 interview and document review, the licensee failed to ensure a client was free from maltreatment (neglect) for one of one clients (C1) reviewed, when staff failed to respond to a client's declining condition by either notifying the client's Nurse Practitioner (primary care provider), calling for emergency medical service, or by providing life-sustaining treatment, and the client expired in the home without receiving any health care intervention, despite being under the care of continuous nursing service. This practice resulted in a level four violation (a violation that results in serious injury, impairment or death) and is 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). The findings include: Medical record review indicated C1 was admitted with diagnoses that included chronic respiratory failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. C1's care plan, dated 12/20/2016, indicated C1's code status was full code, meaning resuscitation should be attempted.	0 325		

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0 325	Continued From page 16 A nursing progress note dated 1/25/2017, for the 7:00 a.m. to 7:00 p.m. shift, indicated C1's Nurse Practitioner (NP)-F was contacted due to C1 having an increased temperature, drooling, and drowsiness. NP-F ordered C1 be sent to the hospital for further evaluation. Review of a hospital discharge summary, dated 1/25/2017, indicated C1 was sent to the hospital, diagnosed with a urinary tract infection, prescribed an antibiotic, and was sent back home the same day. A progress note dated 1/27/2017, written by Registered Nurse (RN)-D for the 7:00 a.m. to 7:00 p.m. shift, indicated a call was received from the hospital to discontinue the previously prescribed antibiotic, and that the Nurse Practitioner would call back with new orders, if necessary. C1's ventilator flow sheet, dated 1/27/2017, written by RN-D, indicated C1's vital signs at 8:00 a.m. on 1/27/17 were temperature 99.1, heart rate 105, and blood pressure 181/108. A progress note dated 1/27/17, written by Licensed Practical Nurse (LPN)-E for the 7:00 p.m. to 7:00 a.m. shift indicated the initial assessment of C1 included temperature 99.8, heart rate 70, blood pressure 184/76, oxygen saturation level of 95%, and thick greenish color secretions were noted. At 1:00 a.m., C1's heart rate was greater than 200 and C1's oxygen saturation was zero (normal was greater than 90%). The note indicates LPN-E then administered cardiopulmonary resuscitation (CPR) to C1 and called emergency medical services (EMS). Review of the ambulance service record dated 1/28/2017 indicated EMS dispatched to C1's	0 325		

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0 325	Continued From page 17 location for a report of cardiac arrest, not breathing. The record indicated the chief complaint upon arrival was breathing problem, but that C1 was breathing regularly without difficulty. C1 had strong bilateral radial pulses with an oxygen saturation level of 99%. The report narrative indicated FM-G informed EMS that C1 had a recent head cold and urinary tract infection, and had been in the hospital where C1 was prescribed an antibiotic for the infection. The report indicated Family Member (FM)-G called EMS because C1 was having a hard time breathing and because C1's skin color was very poor. FM-G signed a refusal to go to the hospital, and was advised to continue the antibiotic medication as prescribed by physician and to call 911 back if anything changed or worsened. A progress note dated 1/28/17, written by RN-C for the 7:00 a.m. to 7:00 p.m. shift and for the 7:00 p.m. to 7:00 a.m. shift, indicated C1 now required five liters of oxygen to maintain an oxygen saturation level of 90%, and that C1's feet were cold to the touch. RN-C placed calls to two pharmacies to check for a new antibiotic order, then attempted to reach C1's primary care providers but was placed on hold and did not reach anyone. RN-C was attempting to contact an unknown nurse practitioner, and a medical doctor who was not C1's primary and who was not on C1's face sheet. The note further indicated RN-C wanted to call EMS at 12:00 p.m., but FM-G refused. RN-C called the ventilator company around 1:00 p.m. for trouble shooting assistance when the ventilator began alarming. C1's pulse was faint when checked manually. C1's medication administration record for 1/28/17 indicated C1's blood glucose levels were checked at 8:00 a.m. with a result of 50 mg/dL, and at 8:00 p.m. with a result of 26 mg/dL. C1's ventilator flow	0 325		

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0 325	Continued From page 18 sheet indicated C1's body temperature had dropped from 98.3 at 8:00 a.m. to 94.0 at 3:00 p.m. and C1's oxygen saturation level continued to drop to 82% at 3:00 p.m. and 0% at 9:00 p.m. Review of a ventilator supplier note dated 1/30/2017 indicated a call was received on 1/28/17 at 11:00 a.m. from nursing, stating that the bedside ventilator was alarming with the message "check circuit." The note indicated the person who took the call assisted the nurse with trouble-shooting the alarm, including switching the client to the back-up ventilator. The note indicated the back-up ventilator alarmed also. The note stated "Nurse swapped out the circuit on the bedside vent and hooked up to the test lung. Vent is performing as it should. When pt is placed back on vent alarm continues Low Ve. Let nurse know that it is likely an issue with the patient. Nursing checked her cuff and inflated it some more. This did not fix the problem. I wonder if the cuff is not [sic] longer holding air? Nursing will check this. They will call me back if anything else is needed." The note also stated "Let them know to call 911 with an emergency." A progress note dated 1/29/17, written by RN-D for the 7:00 a.m. to 7:00 p.m. shift indicated that at the beginning of the shift, the client was unresponsive and there was no pulse reading. C1 did not have any bowel or urinary movement throughout the shift and the tube feeding and water flush was still infusing. RN-D wrote, "Vent machine working and assisting client to breathe" and "Staff would continue to give comfort care." C1's medication administration record for 1/29/17 indicated RN-D documented C1's blood glucose level at 8:00 a.m. was 48 mg/dL. A progress note dated 1/29/17, written by RN-D	0 325		

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0 325	Continued From page 19 for the 7:00 p.m. to 7:00 a.m. shift indicated the client continued to be "unresponsive with no pulse." RN-D indicated FM-G was asked to call EMS because C1's body was "cold to touch" and C1 remained unresponsive, but FM-G refused. The note indicates C1 had no bowel or urinary movement, "The vent machine continues to assist client with breathing," and "Staff will continue to give comfort care." A progress note dated 1/30/17, written by RN-D for the 7:00 a.m. to 1:00 p.m. time period stated C1 continued to be unresponsive, and FM-G was again notified at 7:00 a.m. of the client's status. FM-G advised RN-D not to place any calls out until family arrived. The note indicated at approximately 10:00 a.m., family members contacted a funeral home and the funeral home arrived at approximately 12:50 p.m. to pick up C1's body. During an interview on 5/15/17 at 10:00 a.m., RN-D stated she worked the 7:00 a.m. to 7:00 p.m. shift on 1/27/17. RN-D stated she took the phone call to discontinue C1's antibiotic order, although she was unable to recall from where the call originated. RN-D stated she did not believe she updated C1's primary care provider regarding the discontinuation of the antibiotic, but could not remember. RN-D was anticipating a call with a new antibiotic order and had intended to give any updates to the Nurse Practitioner at that time. RN-D stated she did not believe C1 was in any distress, and that there was no reason to contact the Nurse Practitioner. RN-D gave report to LPN-E at the end of her shift and told her C1 had been running a low-grade temperature but it was being controlled by over-the-counter medications. RN-D indicated she also informed C1's family member (FM)-G about the antibiotic being	0 325		

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0 325	Continued From page 20 discontinued. During an interview on 5/8/17 at 11:15 a.m., LPN-E stated that during her shift, C1's oximeter began beeping, prompting LPN-E to call FM-G to the bedside where FM-G was informed of C1's tachycardia (rapid heart rate). LPN-E asked FM-G to call EMS. LPN-E stated she then manually checked C1's pulse but was unable to palpate it at all. LPN-E informed the 911 dispatcher of her finding, and the dispatcher instructed her to initiate CPR. LPN-E stated that during the course of administering CPR, C1's pulse returned, so she stopped chest compressions prior to EMS arrival. LPN-E indicated she was aware of C1's code status being full code because it was in C1's file, and because FM-G told her so. EMS asked FM-G if she wanted C1 to go to the hospital, but FM-G said the doctors were already aware of C1's status, and FM-G refused transport to the hospital that night. LPN-E did not call to update C1's primary care provider of the event, but stated she asked the on-coming day nurse to do so. LPN-E did not update the executive director, whom she considered her supervisor, of the incident. During an interview on 5/11/17 at 9:00 a.m., RN-C stated she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/28/17. RN-C was aware that EMS had been to the home in the early morning hours, but stated she was not aware that LPN-E performed CPR on C1. RN-C also denied that LPN-E asked her to update the primary care providers regarding the incident. RN-C stated she did attempt to contact the primary care provider after unsuccessfully calling two pharmacies in search of a new antibiotic order for C1. RN-C stated she	0 325		

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0 325	Continued From page 21 attempted to call the Nurse Practitioner's office, but the line to which she was transferred was not answered. The same thing happened when she tried to call the physician's office. RN-C stated that C1's oxygen saturation was at 90% on five liters of oxygen, and that this was an indicator something was wrong, because previously the client's oxygen saturation level had been 97-98% on one or two liters of oxygen. RN-C stated she documented a blood glucose level of 50 mg/dL at 8:00 a.m., and that this value was abnormally low. C1 was on a tube feeding which was running well. RN-C was unable to recall what time she re-checked the blood glucose level or what the result was. RN-C stated she had intended to update the Nurse Practitioner of the low blood glucose level if she had been able to reach her by phone. RN-C stated she informed FM-G of the current oxygen liter flow but not about the low blood glucose value. RN-C stated she recommended contacting EMS because she had not been able to obtain a new antibiotic order, was unable to reach a provider, and was concerned regarding the low oxygen saturation levels. RN-C stated FM-G declined to have C1 go to the hospital, and told RN-C that C1 was now on comfort care. RN-C stated she was unable to verify an order for comfort care, as the hospital discharge paperwork was not in C1's file. RN-C stated she would have asked the primary care providers if C1's code status was changed if she had been able to reach them. When the ventilator started beeping, RN-C tried trouble shooting it for five to ten minutes before calling the supplier for assistance. RN-C was instructed via phone to check for a small hole, to change the circuit, and to check the trach ties to make sure they were tight. She did those things and the alarm stopped. RN-C denied being told to hook up the ventilator to the test lung. The alarm did not sound again for	0 325		

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0 325	Continued From page 22 the remainder of her shift. RN-C's assessment of C1 at that time was that C1 was sick with a urinary tract infection, but she was concerned something else was also going on, due to the low oxygen saturation levels and blood glucose levels. RN-C said C1's vitals kept going "back and forth." RN-C did not recall documenting an oxygen saturation level of zero at 9:00 p.m. RN-C reiterated that she wanted the client to go to the hospital but felt that because the family member did not want the client to go, she "didn't have much to work with." RN-C did not know the last time she checked for a pulse on C1. RN-C stated she did not update the executive director, whom she considered the supervisor, regarding the C1's condition. RN-C stated she should not have taken FM-G's word that C1 was on comfort care and that she should have sent C1 to the hospital. During an interview on 5/15/17 at 10:00 a.m., RN-D stated she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/29/17, as well as from 7:00 a.m. to 1:00 p.m. on 1/30/17. RN-D stated the report from RN-C, on 1/29/17 at 7:00 a.m., was C1 was on comfort care now. RN-D stated RN-C told her she had attempted to call C1's primary care providers to verify if there was an order for comfort care but was unable to reach anyone. RN-C also told RN-D she called for assistance to trouble shoot the ventilator during her shift. RN-D assessed C1 and determined C1 had a "fainting pulse." RN-D said she was aware C1's code status was full code, which meant to do everything to keep the client alive. RN-D stated this meant that if C1 was unresponsive with no pulse, CPR should be initiated and EMS should called. RN-D stated that when she documented C1 had no pulse and was unresponsive, she meant C1 had a "fainting pulse" and when she tried to talk to C1, C1 did	0 325		

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0 325	Continued From page 23 not open her eyes. RN-D stated she was not sure if C1 was alive, because she did not think it was in her scope to say whether the client had died. The ventilator was on and working, C1's chest was rising and falling, and the ventilator was not alarming. RN-D stated she could not verify if the client was dead or not dead, "because somebody could have low pulse or no pulse and could still be living." RN-D stated C1's skin was cold to the touch. RN-D said the protocol was to initiate CPR and call EMS in this situation. RN-D stated she attempted to call EMS, but she was unable to because she did not have access to a phone. RN-D stated FM-G had the only phone and would not allow RN-D to make an emergency call. RN-D did not use her phone to call EMS, because she had been given warnings in the past about having her personal phone in the home, so left the phone in her car. RN-D stated her nursing judgment told her to call EMS and do CPR. RN-D stated she checked C1's pulse manually at 7:00 p.m. on 1/29/17, and it was "fading away." RN-D stated the primary care providers were not contacted, throughout the thirty hours RN-D was in the home, when C1 had a documented blood glucose level of 48 mg/dL, had a "fainting" or absent pulse, and had a decrease in body temperature and oxygen saturation. RN-D did not know when the funeral home had been contacted. RN-D said she should have insisted on calling EMS and initiating CPR. During an interview on 5/8/2017 at 10:15 a.m., Family member (FM)-G stated C1's code status was full code. FM-G stated there was no discussion pertaining to comfort care with any providers. FM-G called EMS on 1/27/17 when LPN-E told her to do so. FM-G observed LPN-E doing chest compressions on C1. FM-G told EMS that C1 had just recently been to the hospital and	0 325		

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0 325	Continued From page 24 was given an antibiotic. FM-G stated C1 was stable at that time. FM-G also believed C1 to be stable on 1/28/17, the day the ventilator was alarming, but stated she did not tell RN-C not to send C1 back to the hospital. FM-G stated she believed C1's condition had turned for the worse when she came downstairs the following morning because C1's face was gray. FM-G stated at that time she called C1's children to tell them to come see her. FM-G denied telling anyone not to call 911, and said he trusted the nurses to inform her of what was going on with C1, but they did not. During an interview on 5/11/17 at 1:10 p.m., Family Member-H (FM-H) stated the family's wishes for C1's code status was for C1 to be full code. FM-H stated the last day he saw C1 was two or three days prior to her passing away, and that C1 looked fine then. FM-H said s/he was not aware of any recent discussions about not sending C1 to the hospital anymore, or any hospice or palliative care discussions. An interview with Funeral Director-I (FD-I) on 4/26/17 at 3:40 p.m., indicated C1's body was removed from the home at 8:30 a.m. on 1/30/17. FD-I stated he received a call from a nurse early that morning, however, FD-I did not know the time or the name. FD-I stated after he spoke with the nurse, he then spoke with FM-G and FM-H over the phone. FD-I had been made aware of C1's death the evening prior when a relative of C1's called FD-I at approximately 10:00 p.m. to say C1 had died. FD-I stated he did not have anything official or legal informing him of that, so he could not confirm whether C1 had actually passed away at that time. FD-I stated that in his opinion, rigor mortis (temporary rigidity of the body after death) had already come and gone by the time C1's body was removed from the home	0 325		

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0 325	Continued From page 25 on 1/30/17. During an interview with Nurse Practitioner (NP)-F on 5/5/17 at 4:00 p.m., NP-F stated she assumed care of C1 on 12/23/16. NP-F stated she saw C1 a total of three times in the home and the last face-to-face visit was on 1/26/17, just after C1 had been seen in the Emergency Department on 1/25/17. NP-F stated C1's vital signs were stable that day, but she noted C1 had an increased heart rate of 111. C1's O2 saturation was 100% on the ventilator, with one liter of oxygen. NP-F stated C1's medical record said multiple times that she was full code, and NP-F had not discussed changing that with C1's family. NP-F stated she had not been contacted by nursing on 1/27/17 regarding on-going fevers with increased greenish secretions. NP-F stated she would have recommended C1 have another set of labs drawn, such as a white blood count, a procalcitonin, and a chest x-ray. NP-F stated she was not informed that a nurse performed CPR on C1 during the overnight hours of 1/27/17-1/28/17, and there was no note regarding it in the written record, which would indicate the clinic had not been notified. NP-F stated she would have sent the client to the hospital immediately if she had been aware CPR was administered. NP-F was not made aware on 1/28/17 of the increased oxygen demands, low blood glucose readings, or faint pulse. NP-F stated C1's hypoglycemia should have been treated with glucagon, after a re-check of C1's blood glucose to verify the number was accurate. NP-F stated she would have told staff to make sure C1 was getting her tube feeding, and to hold the insulin. NP-F was not contacted on 1/28/17 when the ventilator alarmed. NP-F stated that given the cluster of recent symptoms along with ventilator issues, she would have strongly recommended C1 be sent to	0 325		

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0 325	Continued From page 26 the hospital. NP-F stated she believed FM-G would have wanted continued aggressive therapy for C1. NP-F stated she would have required clarification from FM-G if she had wanted to change her plan of care to include end of life hospice care. NP-F was concerned the nursing staff may have been attempting to contact C1's previous providers. NP-F stated that if C1 had an infectious process going on, and had been admitted to the hospital, it likely could have been treated, producing a different outcome. During an interview on 5/9/2017 at 9:03 a.m., Director of Nursing (DON)-B indicated she was not informed by the nurse regarding C1's hospitalization on 1/25/17, rather, she was told later by ED-A that C1 had a high pulse and was admitted to the hospital. DON-B was not informed of LPN-E performing CPR on C1 until two days later, when ED-A told her. DON-B was not contacted by RN-C on 1/28/17 when C1 had blood glucose readings of 50 mg/dL and 26 mg/dL, and also was not contacted about RN-C having trouble with the ventilator or that RN-C had wanted to call EMS for C1. DON-B was not aware C1 had increased oxygen demands or a faint pulse on 1/28/17. DON-B stated she also works with clients in the home and often misses calls, but that ED-A, who is an LPN, usually gets the active calls and will update DON-B via text message. DON-B stated that if staff do not get a call back from a provider after leaving a message, staff are supposed to follow up with the provider again in a couple of hours, if still no response, DON-B or ED-A should be notified. DON-B stated she was not contacted by RN-D on 1/29/17 about C1 not having a pulse and did not learn of it until 1/30/17. DON-B stated C1's code status was full code and that full code meant to do everything to the keep the client alive and to	0 325		

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0 325	Continued From page 27 call 911 if the client's condition required it. C1's code status was located in her chart and DON-B was unaware of any order given for C1 regarding comfort care. DON-B stated if she had been informed by the nurse about FM-G declining to have C1 go to the hospital following the administration of CPR on 1/27/17, she would have discussed the decision with FM-G. DON-B stated the protocol if a full code client is found without a pulse is to start CPR and call EMS. DON-B stated RN-D should have called the physician, director of nursing, charge nurse, or the executive director regarding C1's decline. An interview with Executive Director (ED-A) on 4/25/17 at 1:09 p.m. indicated she was aware that C1's code status was full code. ED-A said there was no order given for comfort care for C1. ED-A stated she did not receive an update during the 1/27/17 shift when LPN-E administered CPR to C1. ED-A was informed the next morning that EMS was called to the home, but was told that EMS said everything was fine. ED-A said that LPN-E should have called to update a supervisor or a registered nurse that she had to give CPR to C1. ED-A spoke with RN-C on 1/28/17 when ED-A happened to call C1's home. RN-C informed her she had placed a call to the doctor's office with no response, and that RN-C had wanted to call EMS. ED-A stated she instructed RN-C to call the doctor's office again but that RN-C did not mention the blood glucose level to ED-A. RN-C informed ED-A that the ventilator had alarmed. ED-A stated the physician should have been notified and if there was no response, EMS should have been called. ED-A stated she thought the nurse on duty should have called 911. ED-A stated she received a call from RN-D at about 7:00 p.m. or 8:00 p.m. on 1/29/17. RN-D told ED-A that C1's pulse was fainting and the	0 325		

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0 325	Continued From page 28 ventilator was working. ED-A stated that if she had been notified that C1 had no pulse, she would have instructed RN-D to call EMS. ED-A stated she did not receive a call from RN-D to say she thought C1 had died. ED-A stated she expected staff to call either EMS or the physician's office, and to initiate CPR. The licensee's undated policy titled, "Cardiopulmonary Resuscitation (CPR)" indicates it is the licensee's policy to attempt CPR for all persons requiring help due to a medical emergency of cardiac and/or respiratory arrest, unless there is an established do not resuscitate (DNR) order in place. The policy further indicates that if a staff member is unsure if a DNR order exists, the CPR policy must be followed. The licensee's undated policy titled "Advance Directives" indicates on page five that if a patient or the patient's representative revokes or attempts to revoke an Advance Directive, then the patient's attending physician and the agency shall be contacted immediately and notified of the revocation or attempted revocation, and if there are any questions regarding an Advance Directive for a patient, to contact the patient's physician and the supervisor. On page six, the policy further indicates that if a dispute arises concerning an Advance Directive, then the agency shall contact the patient's physician immediately and follow the decision and orders of the patient's physician regarding the resolution of the dispute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		

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0 805	Continued From page 29	0 805		
0 805 SS=H	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report an incident of suspected neglect to the Minnesota Adult Abuse Reporting Center (MAARC) when staff did not provide life-sustaining treatment for one of one (C1) clients reviewed. This deficient practice resulted in a level three violation (a violation that harmed a client's health or safety, not leading to serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is 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 occurred repeatedly but is not found to be pervasive). The findings include: Medical record review indicated C1 was admitted with diagnoses that included chronic respiratory failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. C1's care plan, dated 12/20/2016, indicated C1's code status was full code, meaning resuscitation should be attempted. A progress note, dated 1/28/17, written by	0 805		

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0 805	Continued From page 30 Registered Nurse (RN-C) for the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift, indicated C1's was exhibiting symptoms of a rapid decline in health, including increased oxygen demand, faint pulse, and hypoglycemia. A nursing progress note dated 1/29/17, written by RN-D for the 7:00 a.m. to 7:00 p.m. shift indicated that at the beginning of the shift, the client was unresponsive and there was no pulse reading. C1 did not have any bowel or urinary movement throughout the shift and the tube feeding and water flush was still infusing. The note does not indicate there was any attempt to contact C1's medical provider, call emergency medical services, or initiate CPR. A progress note, dated 1/29/17, written by RN-D for the 7:00 p.m. to 7:00 a.m. shift stated C1 continued to be unresponsive with no pulse. RN-D advised family member (FM-G) to call EMS, however, EMS was not contacted. The note does not indicate that RN-D made any independent attempt to call EMS or a medical provider. A progress note, dated 1/30/17, written by RN-D for the 7:00 a.m. to 1:00 p.m. time period stated C1 continued to be unresponsive. At approximately 10:00 a.m., family members contacted a funeral home, and the funeral home arrived at approximately 12:50 p.m. to pick up C1's body. During an interview on 5/11/17 at 9:00 a.m., RN-C said she did not reach C1's medical provider or call EMS in response to C1's symptoms. RN-C was aware of C1's code status. During an interview on 5/15/17 at 10:00 a.m.,	0 805		

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0 805	Continued From page 31 RN-D said she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/29/17, as well from 7:00 a.m. to 1:00 p.m. on 1/30/17. RN-C was aware of C1's code status. RN-D stated that if C1 was unresponsive with no pulse, cardiopulmonary resuscitation (CPR) was supposed to be initiated and EMS was supposed to be called. During an interview with Director of Nursing (DON-B) on 5/9/2017 at 9:03 a.m., DON-B stated C1's code status was full code. DON-B stated the protocol if a full code client is found without a pulse is to start CPR and call for help. DON-B stated RN-D should have called the physician, director of nursing, charge nurse or the executive director for assistance. During an interview with Executive Director (ED-A) on 4/25/17 at 1:09 p.m., ED-A stated C1's code status was full code, so ED-A would expect her staff to have initiated CPR and to have called EMS even if the family was hesitant to do so. Document review and interviews did not identify any evidence that the licensee reported the incident to the Minnesota Adult Abuse Report Center. The licensee's undated policy titled, "Reporting Abuse, Neglect or Exploitation" indicated all suspected abuse, neglect, or exploitation of a patient will be reported immediately to the appropriate agencies. All home care staff were required to report the circumstance of abuse, neglect, or exploitation of patients or other individuals in the home upon discovery. The policy defines neglect as, "The failure to provide for one's self, the goods or services including medical services, which are necessary to avoid	0 805		

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0 805	Continued From page 32 physical or emotional harm or pain or the failure of a caretaker to provide such goods or services." TIME PERIOD FOR CORRECTION: Seven (7) days.	0 805		
0 840 SS=H	144A.4791, Subd. 4 Acceptance of Clients Subd. 4. Acceptance of clients. No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee accepted one of one client (C1) reviewed without sufficient staff in qualifications, competency, and numbers to adequately provide the services agreed to in the service plan. The licensee failed to provide awake staff to provide reasonable and necessary supervision, which the client's family member (FM-G) believed the licensee had agreed to provide. This deficient practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death) and is 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:	0 840		

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0 840	Continued From page 33 C1's record was reviewed. C1 received comprehensive home care services from the licensee, to include private duty nursing for vent dependent , according to a Service Plan dated June 15, 2016. C1 was admitted with diagnoses that included chronic respiratory failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. C1's care plan, dated 12/20/2016, indicated C1's code status was full code, meaning resuscitation should be attempted. A document titled, "Home Health Certification and Plan of Care," signed by the registered nurse on June 15, 2016, and by C1's physician on July 14, 2016, indicates C1 required 24 hour a day nursing with 24 hour supervision. A document titled "Private Duty Nursing Plan of Care," signed by the registered nurse on December 20, 2016 indicated if a client is 24 hour vent dependent, staff are to stay with the client at all times, and nursing is to assess and monitor C1's trach continuously due to risk of de-cannulation, tracheal plug, and desaturation. Review of C1's monthly nursing schedule for December 2016 and January of 2017 indicated nurses were scheduled for twenty-four hour shifts seven times; a thirty-four hour shift one time; thirty-six hour shifts eight times; and a forty-eight hour shift one time. Review of C1's progress notes from December 2016 and January of 2017 indicated RN-C worked twenty-four hours four times and thirty-six	0 840		

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0 840	Continued From page 34 hours two times. RN-D worked twenty-four hours three times, thirty-four hours one time, thirty-six hours six times, and forty-eight hours one time. During an interview on May 8, 2017 at 10:15 a.m., Family Member (FM)-G stated she often checked in on C1 at all hours of the night, and it was not uncommon to find nurses sleeping in the home. FM-G stated nurses worked long shifts because of a lack of trained nurses. FM-G stated that she once asked ED-A to have a nurse removed from C1's case, and ED-A told FM-G there were not enough nurses to do so. During an interview on May 9, 2017 at 9:03 a.m., Director of Nursing (DON)-B said nurses were only supposed to be scheduled for twelve hour shifts. DON-B denied awareness of nurses being scheduled for twenty-four or thirty-six hour shifts. DON-B stated she does not have control over the nursing schedules, because it was handled by ED-A and the office secretary. DON-B stated she was unaware of a staffing shortage. During an interview on May 15, 2017 at 10:00 a.m., Registered Nurse (RN)-D stated it is widely known nurses should not sleep on the job. RN-D acknowledged having worked twenty-four to thirty-six hour shifts regularly. RN-D stated nurses take breaks for fifteen minutes every two hours and a thirty minute break every four hours in the house if the client is stable and resting. RN-D stated if the client is not ok, the nurses must use their discretion. RN-D stated she often goes to work, checks the schedule to see who is scheduled after her, and finds an opening on the schedule. RN-D indicated she will then place a call to ED-A and is told to be patient because ED-A is trying to find someone to cover. RN-D stated she will continue to call ED-A to say she is	0 840		

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0 840	Continued From page 35 still there, that nobody has come in, and she will be there until the shift ends on a shift she was not supposed to work. RN-D stated nurses call in a lot, and she stays because she cannot leave the client alone. During an interview on April 25, 2017 at 1:09 p.m., Executive Director (ED)-A stated she did most of the scheduling for the client's homes, although sometimes the office secretary does it. ED-A stated nurses are not allowed to sleep on the job and indicated there is a policy against it. ED-A denied that any nurse was scheduled to work more than twenty-four hours, stating that although a nurse might work "twenty-some" hours, they would not work with a client for thirty-six continuous hours. ED-A indicated long shifts are only in extreme cases when the family is unable to care for the client. ED-A stated it was RN-D's handwriting on the schedules provided for C1's home for December 2016 and January 2017. ED-A stated RN-D would sometimes write herself in the schedule, but would then later find someone else to cover the shift. If a nurse is working a twenty-four to thirty-six hour shift it is because someone must have called in, but ED-A added that if there was a call in, it would be indicated by a slash through that nurses' name on the schedule. ED-A stated there were no slashes through the December 2016 and January 2017 schedules. A document titled, "Uniform Consumer Information Guide" and dated, January 6, 2017, indicates on page five, staff are available 24 hours a day, seven days per week and the staff person will be awake at all times. A policy titled "Corrective Action" and dated January 1, 2017, indicates on page one, sleeping	0 840		

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0 840	Continued From page 36 on duty is a violation of policy. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 840		
0 870 SS=A	144A.4791, Subd. 9(f) Contents of Service Plan (f) The service plan must include: (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences; (2) the identification of the staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring reviews or assessments of the client; (4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and (5) a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) information and a method for a client or client's representative to contact the home care provider; (iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and	0 870		

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0 870	Continued From page 37 information as to who has authority to sign for the client in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters. This MN Requirement is not met as evidenced by: Based on document review and interview, the service plan for one of one client reviewed (C1) failed to include (1) the schedule and methods of monitoring reviews or assessments of the client; (2) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and (3) a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) information and a method for a client or client's representative to contact the home care provider; (iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters. The deficient practice occurred as a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number	0 870		

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0 870	Continued From page 38 of staff are involved or the situation has occurred only occasionally). The findings include: C1's record was reviewed. C1 received comprehensive home care services from the facility for assistance with Private Duty Nursing for Vent Dependent according to a Service Plan dated June 15, 2016. C1 was admitted with diagnoses that included chronic respiratory failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. On April 4, 2017, at 1:09 p.m., Executive Director A (ED-A) and the surveyor reviewed client #1's service plan. ED-A stated C1's service plan failed to include the required data. ED-A stated the service plan was a copy and there might have been pages missing from the original. ED-A stated she would check the original for the missing information, but no additional pages were provided. A policy titled, "Service Plans" dated, February 1, 2017 indicates the service plan must include all of the required content as indicated above. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 870		
0 890 SS=K	144A.4791, Subd. 13 Discontinuation of Life-Sustaining Treatment Subd. 13. Request for discontinuation of	0 890		

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0 890	Continued From page 39 life-sustaining treatment. (a) If a client, family member, or other caregiver of the client requests that an employee or other agent of the home care provider discontinue a life-sustaining treatment, the employee or agent receiving the request: (1) shall take no action to discontinue the treatment; and (2) shall promptly inform the supervisor or other agent of the home care provider of the client's request. (b) Upon being informed of a request for termination of treatment, the home care provider shall promptly: (1) inform the client that the request will be made known to the physician who ordered the client's treatment; (2) inform the physician of the client's request; and (3) work with the client and the client's physician to comply with the provisions of the Health Care Directive Act in chapter 145C. (c) This section does not require the home care provider to discontinue treatment, except as may be required by law or court order. (d) This section does not diminish the rights of clients to control their treatments, refuse services, or terminate their relationships with the home care provider.	0 890		

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0 890	Continued From page 40 (e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by clients under those chapters. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide life-sustaining treatment when a family member (FM-G) requested that an employee discontinue a life-sustaining treatment. Over the course of two days, two staff failed to inform the supervisor or the client's physician of the request. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and is 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: Medical record review indicated C1 was admitted with diagnoses that included chronic respiratory failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. C1's care plan, dated 12/20/2016, indicated C1's code status was full code, meaning resuscitation should be attempted. A nursing progress note dated 1/28/17, written by Registered Nurse (RN)-C for the 7:00 a.m. to 7:00 p.m. shift and for the 7:00 p.m. to 7:00 a.m.	0 890		

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	H30405	A. BUILDING: _____ B. WING _____	C 05/19/2017

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0 890	Continued From page 41 shift, indicated C1 now required five liters of oxygen to maintain an oxygen saturation level of 90%, and that C1's feet were cold to the touch. RN-C placed calls to two pharmacies to check for a new antibiotic order, then attempted to reach C1's primary care providers but was placed on hold and did not reach anyone. RN-C was attempting to contact an unknown nurse practitioner, and a medical doctor who was not C1's primary and who was not on C1's face sheet. The note further indicated RN-C wanted to call EMS at 12:00 p.m., but FM-G refused. RN-C called the ventilator company around 1:00 p.m. for trouble shooting assistance when the ventilator began alarming. C1's pulse was faint when checked manually. C1's medication administration record for 1/28/17 indicated C1's blood glucose levels were checked at 8:00 a.m. with a result of 50 mg/dL, and at 8:00 p.m. with a result of 26 mg/dL. C1's ventilator flow sheet indicated C1's body temperature had dropped from 98.3 at 8:00 a.m. to 94.0 at 3:00 p.m. and C1's oxygen saturation level continued to drop to 82% at 3:00 p.m. and 0% at 9:00 p.m. Review of a ventilator supplier note dated 1/30/2017 indicated a call was received on 1/28/17 at 11:00 a.m. from nursing, stating that the bedside ventilator was alarming with the message "check circuit." The note indicated the person who took the call assisted the nurse with trouble-shooting the alarm, including switching the client to the back-up ventilator. The note indicated the back-up ventilator alarmed also. The note stated "Nurse swapped out the circuit on the bedside vent and hooked up to the test lung. Vent is performing as it should. When pt is placed back on vent alarm continues Low Ve. Let nurse know that it is likely an issue with the patient. Nursing checked her cuff and inflated it	0 890		

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0 890	Continued From page 42 some more. This did not fix the problem. I wonder if the cuff is not [sic] longer holding air? Nursing will check this. They will call me back if anything else is needed." The note also stated "Let them know to call 911 with an emergency." A progress note dated 1/29/17, written by RN-D for the 7:00 a.m. to 7:00 p.m. shift indicated that at the beginning of the shift, the client was unresponsive and there was no pulse reading. C1 did not have any bowel or urinary movement throughout the shift and the tube feeding and water flush was still infusing. RN-D wrote, "Vent machine working and assisting client to breathe" and "Staff would continue to give comfort care." C1's medication administration record for 1/29/17 indicated RN-D documented C1's blood glucose level at 8:00 a.m. was 48 mg/dL. A progress note dated 1/29/17, written by RN-D for the 7:00 p.m. to 7:00 a.m. shift indicated the client continued to be "unresponsive with no pulse." RN-D indicated FM-G was asked to call EMS because C1's body was "cold to touch" and C1 remained unresponsive, but FM-G refused. The note indicates C1 had no bowel or urinary movement, "The vent machine continues to assist client with breathing," and "Staff will continue to give comfort care." A progress note dated 1/30/17, written by RN-D for the 7:00 a.m. to 1:00 p.m. time period stated C1 continued to be unresponsive, and FM-G was again notified at 7:00 a.m. of the client's status. FM-G advised RN-D not to place any calls out until family arrived. The note indicated at approximately 10:00 a.m., family members contacted a funeral home and the funeral home arrived at approximately 12:50 p.m. to pick up C1's body.	0 890		

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0 890	Continued From page 43 During an interview on 5/11/17 at 9:00 a.m., RN-C stated she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/28/17. RN-C was aware that EMS had been to the home in the early morning hours, but stated she was not aware that LPN-E performed CPR on C1. RN-C also denied that LPN-E asked her to update the primary care providers regarding the incident. RN-C stated she did attempt to contact the primary care provider after unsuccessfully calling two pharmacies in search of a new antibiotic order for C1. RN-C stated she attempted to call the Nurse Practitioner's office, but the line to which she was transferred was not answered. The same thing happened when she tried to call the physician's office. RN-C stated that C1's oxygen saturation was at 90% on five liters of oxygen, and that this was an indicator something was wrong, because previously the client's oxygen saturation level had been 97-98% on one or two liters of oxygen. RN-C stated she documented a blood glucose level of 50 mg/dL at 8:00 a.m., and that this value was abnormally low. C1 was on a tube feeding which was running well. RN-C was unable to recall what time she re-checked the blood glucose level or what the result was. RN-C stated she had intended to update the Nurse Practitioner of the low blood glucose level if she had been able to reach her by phone. RN-C stated she informed FM-G of the current oxygen liter flow but not about the low blood glucose value. RN-C stated she recommended contacting EMS because she had not been able to obtain a new antibiotic order, was unable to reach a provider, and was concerned regarding the low oxygen saturation levels. RN-C stated FM-G declined to have C1 go to the hospital, and told RN-C that C1 was now on comfort care. RN-C stated she was unable to	0 890		

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0 890	Continued From page 44 verify an order for comfort care, as the hospital discharge paperwork was not in C1's file. RN-C stated she would have asked the primary care providers if C1's code status was changed if she had been able to reach them. When the ventilator started beeping, RN-C tried trouble shooting it for five to ten minutes before calling the supplier for assistance. RN-C was instructed via phone to check for a small hole, to change the circuit, and to check the trach ties to make sure they were tight. She did those things and the alarm stopped. RN-C denied being told to hook up the ventilator to the test lung. The alarm did not sound again for the remainder of her shift. RN-C's assessment of C1 at that time was that C1 was sick with a urinary tract infection, but she was concerned something else was also going on, due to the low oxygen saturation levels and blood glucose levels. RN-C said C1's vitals kept going "back and forth." RN-C did not recall documenting an oxygen saturation level of zero at 9:00 p.m. RN-C reiterated that she wanted the client to go to the hospital but felt that because the family member did not want the client to go, she "didn't have much to work with." RN-C did not know the last time she checked for a pulse on C1. RN-C stated she did not update the executive director, whom she considered the supervisor, regarding the C1's condition. RN-C stated she should not have taken FM-G's word that C1 was on comfort care and that she should have sent C1 to the hospital. During an interview on 5/15/17 at 10:00 a.m., RN-D stated she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/29/17, as well as from 7:00 a.m. to 1:00 p.m. on 1/30/17. RN-D stated the report from RN-C, on 1/29/17 at 7:00 a.m., was C1 was on comfort care now. RN-D stated RN-C told her she had attempted to call C1's primary care providers to	0 890		

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0 890	Continued From page 45 verify if there was an order for comfort care but was unable to reach anyone. RN-C also told RN-D she called for assistance to trouble shoot the ventilator during her shift. RN-D assessed C1 and determined C1 had a "fainting pulse." RN-D said she was aware C1's code status was full code, which meant to do everything to keep the client alive. RN-D stated this meant that if C1 was unresponsive with no pulse, CPR should be initiated and EMS should called. RN-D stated that when she documented C1 had no pulse and was unresponsive, she meant C1 had a "fainting pulse" and when she tried to talk to C1, C1 did not open her eyes. RN-D stated she was not sure if C1 was alive, because she did not think it was in her scope to say whether the client had died. The ventilator was on and working, C1's chest was rising and falling, and the ventilator was not alarming. RN-D stated she could not verify if the client was dead or not dead, "because somebody could have low pulse or no pulse and could still be living." RN-D stated C1's skin was cold to the touch. RN-D said the protocol was to initiate CPR and call EMS in this situation. RN-D stated she attempted to call EMS, but she was unable to because she did not have access to a phone. RN-D stated FM-G had the only phone and would not allow RN-D to make an emergency call. RN-D did not use her phone to call EMS, because she had been given warnings in the past about having her personal phone in the home, so left the phone in her car. RN-D stated her nursing judgment told her to call EMS and do CPR. RN-D stated she checked C1's pulse manually at 7:00 p.m. on 1/29/17, and it was "fading away." RN-D stated the primary care providers were not contacted, throughout the thirty hours RN-D was in the home, when C1 had a documented blood glucose level of 48 mg/dL, had a "fainting" or absent pulse, and had a decrease in body temperature	0 890		

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0 890	Continued From page 46 and oxygen saturation. RN-D did not know when the funeral home had been contacted. RN-D said she should have insisted on calling EMS and initiating CPR. During an interview on 5/8/2017 at 10:15 a.m., Family member (FM)-G stated C1's code status was full code. FM-G stated there was no discussion pertaining to comfort care with any providers. FM-G called EMS on 1/27/17 when LPN-E told her to do so. FM-G observed LPN-E doing chest compressions on C1. FM-G told EMS that C1 had just recently been to the hospital and was given an antibiotic. FM-G stated C1 was stable at that time. FM-G also believed C1 to be stable on 1/28/17, the day the ventilator was alarming, but stated she did not tell RN-C not to send C1 back to the hospital. FM-G stated she believed C1's condition had turned for the worse when she came downstairs the following morning because C1's face was gray. FM-G stated at that time she called C1's children to tell them to come see her. FM-G denied telling anyone not to call 911, and said he trusted the nurses to inform her of what was going on with C1, but they did not. During an interview on 5/11/17 at 1:10 p.m., Family Member-H (FM-H) stated the family's wishes for C1's code status was for C1 to be full code. FM-H stated the last day he saw C1 was two or three days prior to her passing away, and that C1 looked fine then. FM-H said s/he was not aware of any recent discussions about not sending C1 to the hospital anymore, or any hospice or palliative care discussions. An interview with Funeral Director-I (FD-I) on 4/26/17 at 3:40 p.m., indicated C1's body was removed from the home at 8:30 a.m. on 1/30/17. FD-I stated he received a call from a nurse early	0 890		

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0 890	Continued From page 47 that morning, however, FD-I did not know the time or the name. FD-I stated after he spoke with the nurse, he then spoke with FM-G and FM-H over the phone. FD-I had been made aware of C1's death the evening prior when a relative of C1's called FD-I at approximately 10:00 p.m. to say C1 had died. FD-I stated he did not have anything official or legal informing him of that, so he could not confirm whether C1 had actually passed away at that time. FD-I stated that in his opinion, rigor mortis (temporary rigidity of the body after death) had already come and gone by the time C1's body was removed from the home on 1/30/17. During an interview with Nurse Practitioner (NP)-F on 5/5/17 at 4:00 p.m., NP-F stated she assumed care of C1 on 12/23/16. NP-F stated she saw C1 a total of three times in the home and the last face-to-face visit was on 1/26/17, just after C1 had been seen in the Emergency Department on 1/25/17. NP-F stated C1's vital signs were stable that day, but she noted C1 had an increased heart rate of 111. C1's O2 saturation was 100% on the ventilator, with one liter of oxygen. NP-F stated C1's medical record said multiple times that she was full code, and NP-F had not discussed changing that with C1's family. NP-F stated she had not been contacted by nursing on 1/27/17 regarding on-going fevers with increased greenish secretions. NP-F stated she would have recommended C1 have another set of labs drawn, such as a white blood count, a procalcitonin, and a chest x-ray. NP-F stated she was not informed that a nurse performed CPR on C1 during the overnight hours of 1/27/17-1/28/17, and there was no note regarding it in the written record, which would indicate the clinic had not been notified. NP-F stated she would have sent the client to the hospital immediately if she had	0 890		

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0 890	Continued From page 48 been aware CPR was administered. NP-F was not made aware on 1/28/17 of the increased oxygen demands, low blood glucose readings, or faint pulse. NP-F stated C1's hypoglycemia should have been treated with glucagon, after a re-check of C1's blood glucose to verify the number was accurate. NP-F stated she would have told staff to make sure C1 was getting her tube feeding, and to hold the insulin. NP-F was not contacted on 1/28/17 when the ventilator alarmed. NP-F stated that given the cluster of recent symptoms along with ventilator issues, she would have strongly recommended C1 be sent to the hospital. NP-F stated she believed FM-G would have wanted continued aggressive therapy for C1. NP-F stated she would have required clarification from FM-G if she had wanted to change her plan of care to include end of life hospice care. NP-F was concerned the nursing staff may have been attempting to contact C1's previous providers. NP-F stated that if C1 had an infectious process going on, and had been admitted to the hospital, it likely could have been treated, producing a different outcome. During an interview on 5/9/2017 at 9:03 a.m., Director of Nursing (DON)-B indicated she was not informed by the nurse regarding C1's hospitalization on 1/25/17, rather, she was told later by ED-A that C1 had a high pulse and was admitted to the hospital. DON-B was not informed of LPN-E performing CPR on C1 until two days later, when ED-A told her. DON-B was not contacted by RN-C on 1/28/17 when C1 had blood glucose readings of 50 mg/dL and 26 mg/dL, and also was not contacted about RN-C having trouble with the ventilator or that RN-C had wanted to call EMS for C1. DON-B was not aware C1 had increased oxygen demands or a faint pulse on 1/28/17. DON-B stated she also	0 890		

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0 890	Continued From page 49 works with clients in the home and often misses calls, but that ED-A, who is an LPN, usually gets the active calls and will update DON-B via text message. DON-B stated that if staff do not get a call back from a provider after leaving a message, staff are supposed to follow up with the provider again in a couple of hours, if still no response, DON-B or ED-A should be notified. DON-B stated she was not contacted by RN-D on 1/29/17 about C1 not having a pulse and did not learn of it until 1/30/17. DON-B stated C1's code status was full code and that full code meant to do everything to the keep the client alive and to call 911 if the client's condition required it. C1's code status was located in her chart and DON-B was unaware of any order given for C1 regarding comfort care. DON-B stated if she had been informed by the nurse about FM-G declining to have C1 go to the hospital following the administration of CPR on 1/27/17, she would have discussed the decision with FM-G. DON-B stated the protocol if a full code client is found without a pulse is to start CPR and call EMS. DON-B stated RN-D should have called the physician, director of nursing, charge nurse, or the executive director regarding C1's decline. An interview with Executive Director (ED-A) on 4/25/17 at 1:09 p.m. indicated she was aware that C1's code status was full code. ED-A said there was no order given for comfort care for C1. ED-A stated she did not receive an update during the 1/27/17 shift when LPN-E administered CPR to C1. ED-A was informed the next morning that EMS was called to the home, but was told that EMS said everything was fine. ED-A said that LPN-E should have called to update a supervisor or a registered nurse that she had to give CPR to C1. ED-A spoke with RN-C on 1/28/17 when ED-A happened to call C1's home. RN-C	0 890		

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0 890	Continued From page 50 informed her she had placed a call to the doctor's office with no response, and that RN-C had wanted to call EMS. ED-A stated she instructed RN-C to call the doctor's office again but that RN-C did not mention the blood glucose level to ED-A. RN-C informed ED-A that the ventilator had alarmed. ED-A stated the physician should have been notified and if there was no response, EMS should have been called. ED-A stated she thought the nurse on duty should have called 911. ED-A stated she received a call from RN-D at about 7:00 p.m. or 8:00 p.m. on 1/29/17. RN-D told ED-A that C1's pulse was fainting and the ventilator was working. ED-A stated that if she had been notified that C1 had no pulse, she would have instructed RN-D to call EMS. ED-A stated she did not receive a call from RN-D to say she thought C1 had died. ED-A stated she expected staff to call either EMS or the physician's office, and to initiate CPR. The licensee's undated policy titled, "Cardiopulmonary Resuscitation (CPR)" indicates it is the licensee's policy to attempt CPR for all persons requiring help due to a medical emergency of cardiac and/or respiratory arrest, unless there is an established do not resuscitate (DNR) order in place. The policy further indicates that if a staff member is unsure if a DNR order exists, the CPR policy must be followed. The licensee's undated policy titled "Advance Directives" indicates on page five that if a patient or the patient's representative revokes or attempts to revoke an Advance Directive, then the patient's attending physician and the agency shall be contacted immediately and notified of the revocation or attempted revocation, and if there are any questions regarding an Advance Directive for a patient, to contact the patient's physician	0 890		

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0 890	Continued From page 51 and the supervisor. On page six, the policy further indicates that if a dispute arises concerning an Advance Directive, then the agency shall contact the patient's physician immediately and follow the decision and orders of the patient's physician regarding the resolution of the dispute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 890		
01080 SS=D	144A.4794, Subd. 3 Contents of Client Record Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the	01080		

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	H30405	A. BUILDING: _____ B. WING _____	C 05/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOME HEALTH CARE INC	5701 SHINGLE CREEK PKWY #631 BROOKLYN CENTER, MN 55430

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01080	Continued From page 52 needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights; (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure the content of the client's record was updated with the name, address, and telephone numbers of the client's health provider, for one of one client (C1) reviewed. This deficient 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 is issued at an isolated scope (when	01080		

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01080	Continued From page 53 one or a limited number or clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Document review of C1's primary care clinic notes indicated C1 was seen in-clinic on 11/7/16 to establish care, however, a referral was later made on 11/22/16 for C1's care to be transferred to a complex care clinic due to difficulty getting C1 to medical offices. An interview with C1's Nurse Practitioner (NP)-F on 5/5/17 at 4:00 p.m., indicated NP-F assumed care for C1 on 12/23/16 as primary care provider through another organization's complex primary care. Document review of C1's face sheet during a site visit on 4/25/17 at 11:45 a.m., indicated C1's face sheet contained the name, address, and phone number for C1's former primary care provider with another health group, and did not contain contact information for the correct clinic. A progress note dated 1/28/17, written by RN-C for the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift, indicated RN-C attempted to reach C1's primary care providers but was placed on hold and did not reach anyone. The note indicated RN-C was attempting to contact an unknown nurse practitioner and a medical doctor who was not on C1's face sheet. An interview with RN-C on 5/11/2014 at 9:00 a.m., indicated she contacted a nurse practitioner's office on 1/28/17, but was unable to recall the nurse practitioner's name. During an interview with Director of Nursing	01080		

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01080	Continued From page 54 (DON)-B on 5/9/2017 at 9:03 a.m., DON-B said she was unaware of the client's care being transferred to a new clinic on 12/23/16, stating she knew Family Member (FM)-G was considering it but was she was not informed of a transfer being done. DON-B did not provide an explanation of why C1's face sheet was not updated, but stated there is a secretary in the office that does all of the paperwork, who is responsible for updating the client's records when a transfer is made. When papers pertinent to the client are received, they are normally faxed to the office to be first reviewed by ED-A and then by DON-B. DON-B stated she did not recall receiving a fax regarding a transfer of care. An interview with Executive Director (ED)-A on 5/22/17 at 10:33 a.m., indicated FM-G frequently changed care providers, which, ED-A stated, contributed to staff not always being aware of who the current primary care provider was. ED-A stated that nurses were handwriting new information on the face sheet in the client's home, and due to nurses being busy during the December and January months, C1's file may not have been updated appropriately. The licensee's undated policy titled, "Timeliness and Accuracy of Entries in the Clinical Record" indicated the clinical record will be current, accurate, signed, legible, and dated with the date of the entry by the individual making the entry. The policy further indicates record keeping is essential for providing continuity of care. TIME PERIOD FOR CORRECTION: Seven (7) days	01080		

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01090	Continued From page 55	01090		
01090 SS=A	144A.4794, Subd. 5 Record Retention Subd. 5. Record retention. Following the client's discharge or termination of services, a home care provider must retain a client's record for at least five years, or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of client records if the home care provider ceases business. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to retain the complete record for at least five years, or as otherwise required by state or federal regulations, following the discharge of one of one client (C1) reviewed. This deficient practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety) and is 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). The findings include: Medical record revealed C1 was admitted on 6/15/16, and discharged on 1/30/17. C1's record lacked evidence of current signed physician's orders. During an interview with Director of Nursing (DON)-B on 5/9/17 at 9:03 a.m., DON-B stated when orders are obtained in the home, the protocol is for the in-home nurse to transcribe the orders and then fax the orders to the office to be verified. DON-B stated all orders should have duplicate copies in the office back up file.	01090		

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01090	Continued From page 56 During an interview with the Executive Director (ED)-A on 4/25/17, at 1:09 p.m., ED-A stated all of C1's signed physician orders obtained after her admission date were missing. ED-A stated after C1 discharged, ED-A went to C1's home to collect all of C1's records and could not find them. ED-A stated she went back to C1's home on 4/24/17 to again check for the orders, however, family member (FM)-G had recently moved and the documents were unattainable. ED-A was unable to provide any signed physicians orders dated after the admission orders, which were electronically signed on 7/14/16. The licensee's undated policy titled, "Retention of Clinical Records" indicated the clinical record will be retained as required by law and regulation. The policy further indicated the administrator is responsible for the correct retention of records. TIME PERIOD FOR CORRECTION: Seven (7) days.	01090		
01105 SS=D	144A.4795, Subd. 2 Licensed Health Professionals and Nurses Subd. 2. Licensed health professionals and nurses. (a) Licensed health professionals and nurses providing home care services as an employee of a licensed home care provider must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing client needs,	01105		

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01105	Continued From page 57 planning appropriate home care services to meet client needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure licensed health professionals and nurses providing home care services possessed a current Minnesota license or registration to practice, for one of five nurses reviewed. 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 is 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). The findings include: On 4/27/2017, the surveyor was able to verify current professional licensure with the Minnesota Board of Nursing for employees: DON-B, RN-C, RN-D, and LPN-E. Employee, ED-A, (LPN), license was listed as expired on 7/31/2016. Document review of the April 2017 nursing schedules indicated ED-A was scheduled to work in the home for two of the licensee's nine clients.	01105		

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01105	Continued From page 58 During an interview with ED-A on 4/25/2017 at 1:09 p.m., ED-A verified she works as a nurse in some of the client's homes. During a follow-up interview with ED-A on 5/22/2017 at 10:33 a.m., ED-A was informed by the surveyor that her nursing license was expired. ED-A stated she was unaware of the expiration, indicating she renewed her license in January 2017. ED-A added the late renewal in January was due to an oversight. At the time of the interview, ED-A was out of the country and stated she planned to return on 5/29/2017. ED-A stated upon her return, she would supply a copy of receipt for payment to the Minnesota Board of Nursing by 5/30/2017, but no further information was provided. The licensee's undated policy titled, "Personnel Records" indicates on page one, each item of the employee's record with expiration dates "will be maintained on individual employee payroll record," and "Items with expiration dates are reviewed periodically prior to assigning a patient to an employee. If an item is required, it must be received before patients are assigned to that employee." The policy also lists verification of qualifications with clear expiration dates as a required item of the personnel record. TIME PERIOD FOR CORRECTION: Seven (7) days	01105		
02015 SS=H	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated	02015		

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02015	Continued From page 59 reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	02015		

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02015	Continued From page 60 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report an incident of suspected neglect to the Minnesota Adult Abuse Reporting Center (MAARC) when staff did not provide life-sustaining treatment for 1 of 1 (C1) clients reviewed. This deficient practice resulted in a level three violation (a violation that harmed a client's health or safety, not leading to serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is 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 occurred repeatedly but is not found to be pervasive). The findings include: Medical record review indicated C1 was admitted with diagnoses that included chronic respiratory	02015		

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02015	Continued From page 61 failure, type 2 diabetes mellitus, cerebral infarction, and heart failure. C1 was ventilator dependent, and required tube feeding and assistance of one staff member with dressing, grooming, bathing, incontinence care, transfers, bed mobility, nutrition, and medication administration with diabetic management. C1's care plan, dated 12/20/2016, indicated C1's code status was full code, meaning resuscitation should be attempted. A progress note, dated 1/28/17, written by Registered Nurse (RN-C) for the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift, indicated C1's was exhibiting symptoms of a rapid decline in health, including increased oxygen demand, faint pulse, and hypoglycemia. A nursing progress note dated 1/29/17, written by RN-D for the 7:00 a.m. to 7:00 p.m. shift indicated that at the beginning of the shift, the client was unresponsive and there was no pulse reading. C1 did not have any bowel or urinary movement throughout the shift and the tube feeding and water flush was still infusing. The note does not indicate there was any attempt to contact C1's medical provider, call emergency medical services, or initiate CPR. A progress note, dated 1/29/17, written by RN-D for the 7:00 p.m. to 7:00 a.m. shift stated C1 continued to be unresponsive with no pulse. RN-D advised family member (FM-G) to call EMS, however, EMS was not contacted. The note does not indicate that RN-D made any independent attempt to call EMS or a medical provider. A progress note, dated 1/30/17, written by RN-D for the 7:00 a.m. to 1:00 p.m. time period stated	02015		

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02015	Continued From page 62 C1 continued to be unresponsive. At approximately 10:00 a.m., family members contacted a funeral home, and the funeral home arrived at approximately 12:50 p.m. to pick up C1's body. During an interview on 5/11/17 at 9:00 a.m., RN-C said she did not reach C1's medical provider or call EMS in response to C1's symptoms. RN-C was aware of C1's code status. During an interview on 5/15/17 at 10:00 a.m., RN-D said she worked the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift on 1/29/17, as well from 7:00 a.m. to 1:00 p.m. on 1/30/17. RN-C was aware of C1's code status. RN-D stated that if C1 was unresponsive with no pulse, cardiopulmonary resuscitation (CPR) was supposed to be initiated and EMS was supposed to be called. During an interview with Director of Nursing (DON-B) on 5/9/2017 at 9:03 a.m., DON-B stated C1's code status was full code. DON-B stated the protocol if a full code client is found without a pulse is to start CPR and call for help. DON-B stated RN-D should have called the physician, director of nursing, charge nurse or the executive director for assistance. During an interview with Executive Director (ED-A) on 4/25/17 at 1:09 p.m., ED-A stated C1's code status was full code, so ED-A would expect her staff to have initiated CPR and to have called EMS even if the family was hesitant to do so. Document review and interviews did not identify any evidence that the licensee reported the incident to the Minnesota Adult Abuse Report Center.	02015		

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02015	Continued From page 63 The licensee's undated policy titled, "Reporting Abuse, Neglect or Exploitation" indicated all suspected abuse, neglect, or exploitation of a patient will be reported immediately to the appropriate agencies. All home care staff were required to report the circumstance of abuse, neglect, or exploitation of patients or other individuals in the home upon discovery. The policy defines neglect as, "The failure to provide for one's self, the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services." TIME PERIOD FOR CORRECTION: Seven (7) days.	02015		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 2, 2017

Ms. Fatuma Kamara, Administrator
Alliance Home Health Care Inc
5701 Shingle Creek Pkwy #631
Brooklyn Center, MN 55430

RE: Complaint Number HL30405001

Dear Ms. Kamara :

On November 1, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on May 19, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matt Heffron
Health Regulations Division
Supervisor Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MN

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman
MN Department of Human Services