Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31747001M
Compliance #: HL31747002C

Date Concluded: August 31, 2022

Name, Address, and County of Licensee Investigated:
2 Caring Hands
18712 Euclid Path
Farmington, MN 55024
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jennifer Segal, RN, BSN
Special Investigator
Rhylee Gilb, RN
Investigative Supervisor

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility staff neglected the resident when the resident was left alone on several occasions for up to nine hours without being checked on, changed, or repositioned and the resident developed a pressure ulcer. In addition, facility staff did not help the resident to eat and drink.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was assessed by the facility to require twenty-four care to assist with toileting, positioning, mobility, eating, medication administration and skin care. Video monitoring showed the facility staff neglected to provide the resident with the care and services required and agreed upon. The resident was transported to the hospital and diagnosed with aspiration pneumonia (inhalation of food or liquids into the lungs), stage 4

pressure ulcer, and severe malnutrition. The failure to follow appropriate practices for feeding and repositioning directly contributed to these issues occurring and to the resident's death.

The investigation included interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigation included an onsite visit, interviews, and observations. Record review included the resident's medical record, facility staffing patterns, staff training and staff supervision. The investigator reviewed pertinent facility policy and procedures, incident reports, other complaints, and the facility training program. The investigator coordinated with the resident's case manager and law enforcement. The investigator viewed several hours of video footage from across a two week period.

The resident resided in the assisted living facility and had diagnoses that included dementia, anxiety, and a history of a stage 4 (full thickness, bone/muscle exposed) pressure wound on her coccyx. The resident's service plan included assistance with all personal cares including incontinence care every two hours, repositioning (frequency not indicated), dressing/grooming twice a day, assistance with eating, bathing three times a week, and medication administration. A modification to services indicated post arm fracture, the resident required a total body lift for transfers, continuous oxygen at two liters per minute, and wound care. The resident's assessment indicated the resident was completely dependent on facility staff, required repositioning every two to three hours, and was unable to communicate needs.

The resident's daily service delivery record did not define frequency of services. Staff were expected to note how many times the resident was positioned during the night, on average staff noted the resident was repositioned twice during the night. According to the plan, the resident should have been repositioned four times during the typical night shift.

The resident's progress note indicated at one point the resident's skin was intact. A progress note two weeks later indicated the resident's family member expressed concerns to the nurse and the licensed assisted living director (LALD). The nurse indicated she was working with the house manager to develop and implement a care plan. Ten days later, a nurse note indicated the resident had a contusion on her arm. The nurse reminded staff to notify the RN with any skin related injuries. Two and a half weeks later, a nurse note indicated the resident had bruising on both upper arms and both hands "believed to be result of transferring resident."

Approximately six weeks later, another progress note indicated the resident's skin was still intact. Another month later, an unlicensed personnel (ULP) progress noted indicated the resident had both wet and dried feces on her.

An excel document, created by the family member, indicated two weeks later the family member informed the LALD via text message she would be installing a camera in the resident's room due to concerns for safety. A week later, the family member installed the camera.

Review of video from the resident's camera showed nearly continuous footage for a two-week period. On three consecutive dates reviewed, the video showed ULP staff sleeping through the night shift. The video also showed infrequent repositioning and incontinent care of the resident, greater than every two hours and sometimes up to six hours. The video also showed several occasions of ULP staff feeding food and liquids with a straw to the resident laying flat or lower than 45 degrees. One staff person fed the resident large bites of food and did not allow the resident time to chew and swallow before giving the next bite. The resident was observed shaking head no or putting hand up to stop and the staff continued to feed large bites of food in resident's mouth. The resident was left unattended with a drink, unable to manage independently and the drink spilled. The resident was heard on video with a weak cough while being fed in bed. Standard position for feeding is Fowlers position, which is 45 to 60 degrees of the head of the bed raised.

A week before the resident's death, the family member showed the LALD the video footage of the inadequate care and sleeping ULP staff.

Five days after the LALD saw the video, a ULP progress note indicated after dinner the resident had two emesis. ULP staff called the nurse and was instructed to take vitals and monitor. During the night, at 1:35 a.m., ULP staff gave the resident a sip of water. The resident coughed, had a loose stool and had another emesis. Staff sent the resident to the hospital.

The resident's hospital record titled "Death Summary" indicated the resident's final diagnoses included aspiration pneumonia, stage 4 coccyx wound and severe malnutrition in context of chronic illness.

The resident's death record incident the resident died on two days after hospitalization and primary cause of death was aspiration pneumonia.

During an interview, the nurse stated she was the registered nurse (RN) for seven of the different facilities owned by the same owner, with five to six residents in each house. The RN stated she was also working a separate full-time job. The nurse stated the owners were determining admission of residents and no RN was performing an assessment prior to admission. When asked who trained the staff to provide cares, the nurse stated "no one," however she would inform staff of what the resident's care needs were. The nurse stated staff were directed to contact the owners for change of condition and the owners were making nursing decisions and deciding when to notify the nurse; the owners were not nurses. The nurse stated she had concerns with staff not feeding the resident properly. The nurse stated she directed staff to get the resident up and not to feed her in bed.

During interview, the resident's family member stated the resident had good care in the past however, there was a significant change in quality of staff. The family member suspected staff were not caring for the resident. The family member inquired about a camera to management and installed one with management's approval. The family member stated within two days of

viewing video footage, family began looking for a new facility because the family witnessed lack of care to the resident across all shifts. The family member planned to move the resident to a new facility the same weekend the resident was hospitalized.

In conclusion, the Minnesota Department of Health determined neglect was substantiated

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility called 911 to obtain emergency services for the resident.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Farmington City Attorney
Farmington Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31747	A. BUILDING: _____ B. WING _____	C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2 CARING HANDS INC	**18712 EUCLID PATH FARMINGTON, MN 55024**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL31747001M #HL31747002C #HL31747003M #HL31747004C #HL31747005M #HL31747006C On December 14, 2021, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 5 residents receiving services under the provider's Assisted Living license. The following immediate correction order is issued for, #HL31747001M #HL31747002C #HL31747003M #HL31747004C and #HL31747005M #HL31747006C tag identification 0470. The following correction order is issued for, #HL31747001M #HL31747002C #HL31747003M	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 Assisted Living Facilities. 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 evaluators' 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 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 #HL31747004C and #HL31747005M #HL31747006C tag identification, 2360. The following correction order is issued for, #HL31747001M #HL31747002C, tag identification 2310.	0 000		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced	0 470		

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0 470	Continued From page 2 by: Based on interview and record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for providing the health and safety needs of three of three residents (R1, R2, R3) reviewed. Therefore, staff did not provide R1, R2, R3 their required services during the night. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included dementia, anxiety, and pressure ulcers. R1's nursing assessment dated July 29, 2020, indicated R1 had a history of a stage 4 (full thickness, bone/muscle exposed) pressure wound on her coccyx. R1's service plan dated November 11, 2020, indicated R1 required toileting every two hours, one to two staff for positioning (frequency not indicated), dressing/grooming twice a day, bathing three times a week, eating assistance and medication assistance. A modification to services, undated, indicated post humerous fracture, R1 required a hoyer (total body lift) for transfer, continuous oxygen at two liters per minute, and wound care (frequency illegible). A note dated February 17, 2021, on the modification form indicated behaviors of yelling out.	0 470		

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0 470	Continued From page 3 R1's progress note dated May 12, 2021, indicated R1's skin was intact. Progress noted dated June 11, 20221, indicated R1's family member (FM)-C expressed concerns of care to registered nurse (RN)-K and the house manager (licensed assisted living director (LALD)-A). RN-K indicated he was working with the house manager to develop/implement continuity of a care plan. R1's progress note dated July 30, 2021, indicated R1's skin was intact. Unlicensed personnel (ULP) progress noted dated August 29, 2021, indicated R1 had both wet and dried feces on her. An excel document created by FM-C, indicated on September 17, 2021, FM-C informed LALD-A via text message she would be installing a camera in R1's room due to concerns for safety. On September 24, 2021, FM-C had the camera installed. Review of video from R1's camera showed on September 28, 2021, September 29, 2021 and September 30, 2021 staff sleeping through the night shift. The video also showed infrequent repositioning and incontinent care of R1, greater than every two hours. FM-C's excel document indicated on October 2, 2021, FM-C showed LALD-A the video footage of inadequate care and sleeping staff. R1's ULP progress note dated October 7, 2021, indicated staff sent R1 to the hospital for a change in condition. R1's hospital record dated October 9, 2021, titled "Death Summary" indicated R1's final diagnoses included stage 4 coccyx wound and severe	0 470		

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0 470	Continued From page 4 malnutrition in context of chronic illness. R2's diagnoses included acute deep vein thrombosis (blood clot in legs), congestive heart failure, morbid obesity, left ankle fracture, major depression R2's service plan dated May 7, 2021, indicated R2 received assistance with medication administration, bathing, grooming/dressing twice a day, incontinence care (frequency not indicated) and transfers. R2's RN assessment dated June 6, 2021, indicated R2 was a high fall risk. An incident report dated June 24, 2021, indicated at 2:25 a.m. R2 fell while walking back to his room from the bathroom. An incident report on July 12, 2021, (time unclear written "7 p.m. 45 p.m."), indicated R2 slid out of bed and required a lift to pick him up and put him back into bed. R2's progress noted dated July 20, 2021, indicated R2 had been walking with physical therapy (PT) and has been going well. RN-K indicated walking had improved. Progress noted dated July 22, 2021, indicated PT will discharge next week. RN-K indicated R2 had improved in lower leg strength and range of motion. An incident report dated July 25, 2021, at 3:30 p.m., indicated R2 fell while trying to self change his incontinent product. An incident report dated August 14, 2021, at 4:30 p.m., indicated R2's knee gave out while he was walking on the deck and fell. R2 transported to the hospital. An incident report dated August 15, 2021, at 5:00 p.m., indicated R2 fell from bed trying to stand with walker.	0 470		

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0 470	Continued From page 5 R2's progress note on August 17, 2021, indicated R2 had a pre-operative appointment on August 20, 2021, for a left ankle surgery for a fracture on August 23, 2021. On August 20, 2021, transportation failed to arrive to take R2 to appointment. On August 27, 2021, surgery had been rescheduled for August 30, 2021. On August 31, 2021, R2 discharged back to the licensee post surgery with left ankle dressing changes required and to wear a boot. R2's progress notes dated September 1, 2021 through December 9, 2021, indicated R2 had several hospitalizations related to blood clots in legs and a suspected stroke. On December 12, 2021, R2 returned to the licensee with stroke not indicated. R2 required total assist with repositioning and toileting with the use of a hoyer lift. R2 had 10/10 pain when attempting to turn. R3's diagnoses included hypertension, morbid obesity, history of stroke. R3's service plan dated 12/2/21 indicated R3 received assistance with medication administration, bathing, grooming/dressing twice a day, toileting every two hours, and positioning assistance "as needed". R3's RN assessment dated October 17, 2021, indicated R3 had no falls since admission, was unable to walk and required a hoyer lift for transfer, and skin was intact, but reddened in groin and arm pits. During an interview on December 14, 2021, at 3:12 p.m., R3 stated ULP-B told her not to wake her up during the night shift for toileting or cares. R3 stated often staff make her wait to use the bedpan or be changed because it the end of their shift or tell her she went recently. R3 stated staff often sleep on their shifts, sometimes they work	0 470		

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0 470	Continued From page 6 more that one day straight. R3 said there was no consistent schedule and staff dictated their own schedule. R3 kept a 2015 calendar that was used for year 2021 to log several occasions (more than once) where R3 documented time of bedpan request and either staff denied to help for she had to wait. Review of the licensee's staff schedules indicated the following number of 24 hour shifts schedule each month were: August 2021: seven 24 hour shifts September 2021: twelve 24 hour shifts October 2021: eleven 24 hours shifts November 2021: four 24 hours shifts December 2021: seven 24 hour shifts Majority of the 24 hour shifts were schedule to ULP-H. During an interview on April 29, 2022, at 10:31 a.m., RN-F stated she was the RN for seven of the different facilities owned by the same licensed owner (LALD-A) with five to six residents in each house in addition to working a separate full time job. RN-F stated the owners were determining admission of residents, so no RN was performing an assessment prior to admission. When asked who trained the staff to provide cares, RN-F stated no one, however she would inform staff of what the resident's care needs were. RN-F stated staff were directed to contact the owners for change of condition and the owners were making nursing decsisions, none of which were nurses. RN-F stated she had concerns with staff not providing incontinence cares when she rounded on residents during visits. RN-F described residents soaked all the way through linen [with urine] and told staff they needed to be cleaned and checked on more frequently. RN-F stated she received a call from LALD-A to assess R1's	0 470		

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0 470	Continued From page 7 coccyx around June or July [2020] and RN-F stated she was upset to find R1 had a stage two (partial thickness) wound. RN-F stated she went to the home every day to ensure staff provided care and healed R1's coccyx wound in six months. RN-F stated she instructed staff to assist residents, like R1, who could walk to the restroom, but they did not do so because they were lazy and left residents in bed. During an interview on May 5, 2022, at 11:00 a.m., LALD-A stated staff work 12 hour shifts and sometimes on the weekends work 24 hour shifts. When asked how staff stay awake, LALD-A stated she did not know how they did it, but were paid overtime. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
02310 SS=J	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide standard Fowler's position (head of bed raised between 45 and 60 degrees) for assisting with eating for one of one residents (R1) reviewed who required total assistance with eating. Staff fed R1 while laying flat in bed liquids and food. R1 died of aspiration pneumonia. This practice resulted in a level four violation (a	02310		

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02310	Continued From page 8 violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia, anxiety, and pressure ulcers. R1's nursing assessment dated July 29, 2020, indicated R1 had a history of a stage 4 (full thickness, bone/muscle exposed) pressure wound on her coccyx. R1's service plan dated November 11, 2020, indicated R1 services included eating assistance. R1 unable to communicate needs or obtain help. R1's progress note dated June 11, 20221, indicated R1's family member (FM)-C expressed concerns of care to registered nurse (RN)-K and the house manager (licensed assisted living director (LALD)-A). RN-K indicated he was working with the house manager to develop/implement continuity of a care plan. An excel document created by FM-C, indicated on September 17, 2021, FM-C informed LALD-A via text message she would be installing a camera in R1's room due to concerns for safety. On September 24, 2021, FM-C had the camera installed. Video from R1's camera recorded from September 24, 2021 through October 7, 2021, showed several occasions (more than once) of staff feeding food and liquids with a straw to R1 laying flat or lower than 45 degrees.	02310		

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02310	Continued From page 9 FM-C's excel document indicated on October 2, 2021, FM-C showed LALD-A the video footage of inadequate care and sleeping staff. R1's ULP progress note dated October 6, 2021, indicated after dinner R1 had two emesis. ULP staff called the RN and instructed to take vitals and monitor. During the night on October 7, 2021, at 1:35 a.m., staff gave R1 a sip of water because she sounded dry. R1 coughed, had a loose stool and had another emesis. Staff sent R1 to the hospital. R1's hospital record dated October 9, 2021, titled "Death Summary" indicated R1's final diagnoses included aspiration pneumonia, stage 4 coccyx wound and severe malnutrition in context of chronic illness. R1's death record incident R1 died on October 9, 2021. Primary cause of death was aspiration pneumonia. During an interview on April 29, 2022, at 10:31 a.m., RN-F stated she was the RN for seven of the different facilities owned by the same licensed owner (LALD-A) with five to six residents in each house in addition to working a separate full time job. RN-F stated the owners were determining admission of residents, so no RN was performing an assessment prior to admission. When asked who trained the staff to provide cares, RN-F stated no one, however she would inform staff of what the resident's care needs were. RN-F stated staff were directed to contact the owners for change of condition and the owners were making nursing decisions, none of which were nurses. RN-F stated she had concerns with staff not feeding R1 properly. RN-F stated she directed staff to get her up and don't feed her in bed.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31747	A. BUILDING: _____ B. WING _____	C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 10 When asked why staff left her in bed to eat, RN-F said because they [staff] were lazy. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure three of three residents (R1, R2, R3) reviewed were free from maltreatment. R1, R2 and R3 were neglected. Findings include: On August 31, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. MDH concluded there was a preponderance of evidence that maltreatment occurred	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	