Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31747003M
Compliance #: HL31747004C

Date Concluded: September 1, 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

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 they failed to assist the resident with toileting. The resident was left in bed with 4 incontinent pads underneath him which were soaked with urine down to the bed mattress. In addition, the resident was told by the alleged perpetrator

(AP), facility staff, to “poop in [his] diaper” because the AP did not know how to use mechanical lift to transfer the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect occurred. The facility was responsible for the maltreatment. Multiple staff members and outside health care providers observed the resident soaked with urine on several occasions. Although the AP denied telling the resident to poop in his diaper, the facility failed to ensure staff members were consistently available to meet the needs of the resident.

The investigation included interviews with facility staff including administrative, nursing, and unlicensed staff. The investigation included review of the resident’s facility medical record, home care and hospital records, incident reports, employee records, facility staffing schedules, and facility policy and procedures. Onsite observations of resident cares and the facility environment were completed.

The resident resided in the assisted living facility with diagnoses including congestive heart failure, morbid obesity, and left ankle fracture.

The resident’s medical record indicated the resident required staff assistance with all personal cares including toileting, mobility, bathing, and medication. The resident communicated his needs and had no memory impairment. The resident received additional services from an outside home health care agency.

The resident had frequent hospitalizations which led to a decline in mobility. The resident went from walking with a walker to eventually requiring two staff and a mechanical lift for mobility assistance and the resident became bedbound. The resident’s medical record did not contain specific instructions to direct staff how or when to assist the resident with cares, transfers, and toileting, as the resident’s care needs increased.

Following one of the residents’ hospitalizations, an outside home care provider assessed the resident and indicated the resident had a decline in health status and required extensive assistance from two staff and a mechanical lift to get out of bed.

A home care note indicated the facility staff reported to the home care agency the resident was very difficult to transfer and as a result had not been out of bed since returning from the hospital. Home care staff indicate the resident required extensive assistance of two staff for cares. The home care agency recommended a fully electric hospital bed to decrease burden to caregivers as all personal cares were completed while the resident was in bed.

A report indicated the resident had been observed by facility staff and outside health care providers soaked with urine. Another report indicated the resident was told by the AP to “poop in [his] diaper” because the AP was unable to operate the mechanical lift. The AP was the only

staff in the facility, and the resident needed to wait for another staff member to be assisted with toileting.

The residents home care assessment indicated the resident was having pain and requested to go to the hospital. The resident fractured his ankle approximately one and half months prior, and was very difficult to transfer, turn, and reposition while in bed which resulted in the resident staying in bed much of the time. The resident used a mechanical lift for transfers and the facility had only one staff member working and “it is impossible” to care for the resident effectively [with only one staff]. When the ambulance arrived at the facility to transport the resident, the resident was “very incontinent of urine,” and it took two paramedics, the home health nurse, and a facility staff to change and transfer the resident. The note indicated the nurse recommended the resident be transferred to a transitional care unit from the hospital so the resident could be, “Cared for effectively.”

Another note indicated an outside provider arrived at the facility to complete an evaluation and the resident was soaked in urine. The provider assisted the facility staff to clean and change the resident. A home care note indicated facility staff were overwhelmed with the level of care the resident required.

Another staff member from an outside home care agency noted the resident had a lot of difficulty with therapy during the visit because the resident had not been cleaned yet and was sweaty which was making it difficult to move in bed.

Following another hospitalization, a nurse from an outside agency determined the resident may require placement in another facility due to the current facility only having one staff person working and they are unable to appropriately care for the resident.

A progress note written by a facility staff indicated when beginning her shift at the facility one afternoon the resident was in bed soaked with urine. The staff member indicated she provided the resident a bed bath and changed the bed linens.

The facility staff schedule indicated most of the shifts only had one staff member scheduled to provide cares at the facility. The staff schedule indicated many staff members worked alone during the usual 12-hour shifts, and also frequently had only one staff member scheduled to work alone for 24 to 36 hours straight.
Video footage of the facility common area indicated several staff regularly slept several hours on the couch in the common area during the night and did not wake up to provide any resident care.

During interview with a former facility nurse stated she had “grave concern” about the lack of care provided to the residents. The nurse stated the AP “babysat” the residents; meaning the AP was there to keep an eye on the residents but did not do any direct cares. The nurse stated the resident reported when he asked the AP for assistance with toileting, the AP told the resident to “poop in [his] diaper,” and the resident would need to wait for another staff member to assist the resident.

During interview, management staff stated they were aware the AP couldn’t use the mechanical lift because of an injury, however, they [facility] had “no choice,” but to continue to have the AP work due to the facility lack of staffing.

During interview, management staff stated some staff slept during the night on the couch in the common area, however, staff were still expected to provide care to the residents every two hours during the night and as needed. Management stated staffing was challenging and some staff worked the entire weekend from Friday night to Sunday or Monday.

During interview the AP stated she did not tell the resident to poop in his diaper. The AP stated she told the resident she needed to get the mechanical lift, but the resident stated it was too late. The AP stated another staff member arrived for their shift and the two staff assisted to change and clean the resident together. The AP stated she rarely provided resident cares while working in the facility because she would fill in for short shifts as needed and the residents had cares completed prior to arrival. The AP was unsure if the resident required one or two staff for assistance with transfers using the mechanical lift.

When interviewed the resident stated one staff left him sitting in a soiled brief and he had to wait for the night person to come to the facility to be cleaned and changed. The resident stated he was upset and “felt horrible.”

In conclusion, the Minnesota Department of Health determined neglect is 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: Yes
Family/Responsible Party interviewed: Resident is own guardian
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility stated they have on call staff available 24/7 to assist if an additional staff member is needed.

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

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.	