Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL32084023M
Compliance #: HL32084024C

Date Concluded: January 19, 2021
Date Revised: November 23, 2022

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
800 Boone Avenue North, Ste. 200
Golden Valley, MN 55427
Faribault County

Name, Address, and County of Housing with Services location:
Elmore Assisted Living
202 East North Street
Elmore, MN 56027
Faribault County

Facility Type: Home Care Provider

Investigator's Name:
Lisa Coil, RN Special Investigator
Revised By: Matt Heffron, JD, NREMT
Rapid Response Operations Manager

Finding: Substantiated, facility and individual responsibility

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

Allegation(s):
It is alleged: The facility neglected client #1 by not ensuring health care was provided according to client #1's service plan. The Alleged Perpetrators (AP#1, AP#2, and AP#3) neglected client #1 when they failed to do the following: monitor bowel and abdominal symptoms as ordered; identify and assess significant weight loss; identify, monitor, and assess client #1's declining health and change in condition; and complete a comprehensive assessment upon client #1's return from a hospital stay.

It is alleged: The facility neglected client #2 by not ensuring health care was provided according to client #2's service plan. AP#1, AP#2, and AP#3 neglected client #2 when they failed to identify, monitor, and assess client #2's significant weight loss. The APs did not complete a change in condition assessment when client #2 had a decline in health status and was transported to the emergency room (ER).

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for neglect when it did not ensure implementation of care and services according to client #1 and client #2's needs, and due to systemic failures to completer required assessments. ~~AP#1, AP#2, and~~ AP#3 was also responsible for the maltreatment. AP #3 was assigned to client #1 and client #2, and failed to client #1 and client #2 according to provider orders or to appropriately assess and intervene in a timely manner when the clients experienced changes in condition.

The investigation included a review of client medical records, external medical records, and facility policies. The investigator conducted interviews with administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the clients' guardians and the APs.

Review of facility policies identified that nurses shall conduct assessments, monitoring and reassessments consistent with the Comprehensive Home Care requirements and the individualized needs of each home care client. Facility policies further identified an assessment for changes in client condition should be completed as indicated.

All three APs, who are registered nurses, worked with client #1 and client #2 and were the only facility staff responsible for conducting comprehensive and change in condition assessments and ensuring unlicensed staff implemented the plan of care.

Review of client #1's record indicated the client's diagnoses included, but was not limited to, severe sepsis with septic shock, atrial fibrillation, acute cystitis, paranoid schizophrenia, epilepsy, and Type 2 diabetes. Client #1's service plan indicated he received services for medication management, hourly wellness checks, weekly weights, bowel monitoring, and other activities of daily living. Client #1's comprehensive assessment indicated he had short-term memory impairment.

Review of client #1's medical record indicated client #1 had a recent history of an ileus (a painful obstruction to part of the intestine), which was treated with an aggressive bowel program during a hospitalization. Approximately one month following client #1's return to the facility from hospitalization, client #1's record identified two provider orders to monitor client #1's bowel movements (BMs) and abdominal symptoms closely. The two provider orders were written seven days apart. Client #1's medical record did not identify that nursing staff (the APs) completed any notes or assessments related to client #1's BMs or abdominal symptoms.

Review of client #1's medical record indicated during two separate months, client #1's Medication Administration Record (MAR) included an entry indicating client #1 should have weekly weights. Only one weight was documented on client #1's MAR each of those two months. Client #1's documented weights indicated client #1 experienced a weight loss of approximately 21 pounds in one month. There were no nursing assessments or documentation in client #1's medical records that addressed client #1's weight loss.

Review of client #1's medical record included a nurse's note documented by AP#1 that indicated AP#1 assessed client #1 as very shaky with wheezes throughout his right lung and that he appeared short of breath. AP#1's notes did not identify a plan for treatment or any follow-up monitoring. Approximately 24 hours later, another nurse's note, documented by a Licensed Practical Nurse (LPN), indicated client #1 went to the ER by ambulance due to low oxygen saturation levels, ash-colored skin, and dark colored urine. A second nurse's note documented by AP #1 indicated client #1 was transferred to another hospital and admitted. While there was documentation AP#2 completed client #2's comprehensive assessment, AP #2 only indicated client #1 had a fall but did not mention a decline in his health status as noted in the two nursing notes referenced above. Upon client #1's return from hospitalization, there were no nursing assessments, or any health status documentation noted in client #1's medical record. All three APs worked the day client #1 returned to the facility.

Approximately five days following client #1's return to the facility, a nurse's note documented by the LPN indicated client #1 went to the ER after an episode of unresponsiveness. The LPN's note identified client #1 was assessed in the ER for shortness of breath and atelectasis (a collapse of one or more areas of the lung) and later returned to the facility. After this change in condition, AP#2 documented one nursing note the following day regarding client #1's health status.

Review of client #2's record indicated the client's diagnoses included, but was not limited to, Type 2 diabetes, alcohol abuse, and dementia with behavioral disturbance. Client #2's service plan indicated he received services for medication management, behavior management, fluid intake monitoring, weekly vital signs and weekly weights. Client #2's comprehensive assessment indicated he had intact cognition.

Review of client #2's medical record included vital sign records which identified client #2 had a significant weight loss of 22 pounds in one month. Client #2's record failed to include nurses' notes or any assessments regarding the significant weight change.

Review of client #2's medical record indicated AP#2 documented client #2 experienced wheezing and audible crackles in his lungs, and he was sent to the ER. Client #2's hospital record indicated he was admitted to the hospital for influenza, pneumonia, and diabetic keto acidosis (a life-threatening condition related to diabetes); client #2 later died at the hospital. Client #2's facility record did not include a change in condition assessment.

When interviewed, unlicensed personnel (ULP) stated she did not feel like the nurses assessed client #1 or client #2 in a timely manner. The ULP stated she notified AP#1 and AP#2 mid-morning that client #1 was not himself, and they needed to come and assess him. The ULP stated neither AP#1 nor AP#2 assessed client #1 until later in the day, following a second request for them to assess client #1. Review of a late entry nurse's note documented by the LPN confirmed client #1 was not sent to the ER until later that afternoon.

When interviewed, AP#1 was unable to recall if she worked the day client #1 went to the hospital or the day he returned to the facility. AP#1 was also unable to recall if she worked the day client #2 went to the hospital. Review of the staff schedules for the three days indicated above verified AP #1 worked on all three days. AP#1 stated she did not recall any situation in which she did not respond to the concerns brought to her attention by the ULPs.

Regarding BM and abdominal symptom monitoring, AP#1 stated a task for the BM monitoring would be added to client #1's service plan by AP#3, and an entry to the MAR for abdominal assessments would be added by AP#1, AP#2, or AP#3. AP#1 stated she would enter a progress note in a client's record regarding the assessment of the BMs and abdominal symptoms.

Regarding weight monitoring, AP #1 stated clients are weighed weekly or monthly unless they have a specific provider's order indicating an alternative frequency. AP#1 stated AP#3 entered the frequency of client weights in the service plans but was unsure how AP#3 made the decision on the frequency for each client. AP#1 stated the facility did not have a protocol for significant weight change, but in her nursing opinion, a 10 to 12-pound weight change would be significant and require a nursing assessment. AP#1 stated AP#1 and AP#2 had recognized a problem with inconsistent weight monitoring at the facility and began running a daily report to follow-up on missed or inconsistent entries; however, AP#1 also stated they had not been doing this for a while because it was not a top priority given their list of things to do. AP#1 stated she did not recall being aware of or discussing a significant weight loss for client #1 or client #2.

Regarding change in condition assessments, AP#1 stated client #1 should have had a change in condition assessment completed when he was sent to the ER and when he returned from his hospital stay. AP#1 did not have access to client #1 and client #2's medical records to confirm the missing information. AP#1 further stated training at the facility was minimal, and AP#1 and AP#2 did not have a lot of direction and learned a lot from each other. AP#1 also stated there had not been any re-education provided related to the issues identified above.

When interviewed, AP#2 stated, for the past six months, she primarily cared for the clients in Assisted Living, and AP#1 primarily cared for the clients in Memory Care. Prior to that, each RN was assigned a floor to oversee the clients residing on that floor. She stated, however, all RNs are responsible to assist each other when client needs arise. During the time of alleged neglect, she stated AP#3 was the primary RN caring for client #1 and client #2.

Regarding weight monitoring, AP#2 stated clients are weighed weekly or monthly and could be weighed daily with a provider's order. AP#2 stated the ULPs are supposed to notify the nurse of a five-pound weight change. AP#2 did not recall knowledge of client #1's significant weight loss; however, AP#2 verified she would have completed a change in condition assessment if she would have known about it.

Regarding change in condition assessments, AP#2 stated client #1 should have had a change in condition assessment completed when he returned from the hospital. AP#2 stated a focused

assessment should have a nursing note documented, such as in client #1's case of monitoring BMs and abdominal symptoms. AP#2 recalled assisting with one of client #1's transfers to the hospital but did not recall specific details. AP#2 recalled over-hearing a ULP call for a nurse to go to client #1's room, and AP#2 stated she responded. AP#2 did not recall any further conversations regarding the incident.

When interviewed, AP#3 stated she used to oversee the third-floor clients but was unable to recall when the transition to her current position took place. AP#3 stated any RN in the building is responsible for completing an assessment if they are made aware of a client situation. AP#3 verified she did not complete a change in condition assessment or make a progress note about client #1's health condition when she assessed client #1 prior to his transfer to the ER. AP#3 further verified assessments were missing from client #1 and client #2's medical records.

Regarding BM and abdominal symptom monitoring, AP#3 stated BM monitoring would be on the service plan and documented by the ULPs; abdominal symptoms would be on the electronic MAR and completed by the nurses. AP#3 stated a nursing note summarizing the abdominal assessment should be charted in a client's nursing notes.

Regarding weight monitoring, AP#3 did not recall client #1 or client #2's significant weight change but verified a change in condition assessment should be completed by any one of the nurses, including her, when it is identified. AP#3 stated client #1 should have had a comprehensive assessment (by the RNs) upon return to the facility from a hospital stay.

When interviewed, the Director of Nursing (DON), also an RN, stated she was unaware of the missing change in condition assessments and significant weight changes for both client #1 and client #2. The DON stated she expected focused assessments to be charted in the nursing notes and a change in condition assessment to be completed on anyone with a significant weight change, when going to the ER, and upon return from a hospital stay. The DON stated it is the responsibility of any one of the nurses to complete an assessment. The DON stated she expected the nurses to clarify provider orders stating, "monitor BPs (blood pressure)" and "monitor bowel movements/abdominal symptoms closely" to determine how often the provider wanted those things monitored.

In conclusion, neglect was substantiated against the facility~~, AP#1, AP#2,~~ and AP#3.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. Both clients are deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes, AP#1, AP#2, and AP#3.

Action taken by facility:
No action taken. The facility management was unaware of the lack of nursing assessments until this investigation.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long-Term Care
Faribault County Attorney
Elmore City Attorney
Elmore Police Department
Minnesota Department of Human Services
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32084	A. BUILDING: _____ B. WING _____	C 12/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On December 24, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL32084024C/#HL32084023M. At the time of the investigation, there were #53 clients receiving services under the comprehensive license. The following correction order is issued for #HL32084023M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 325		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

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0 325	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure two of two clients reviewed (C1, C2) were free from maltreatment. C1 and C2 were neglected. Findings include: On January 19, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and three individual staff persons were responsible for the maltreatment.	0 325		