*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints
# Investigative Public Report

**Maltreatment Report #:** HL34364003M
**Compliance #:** HL34364004C

**Date Concluded:** September 24, 2021

**Name, Address, and County of Facility Investigated:**
Whispering Oak Place
903 Calverly Court
Ellendale, MN 56026
Steele County

**Facility Type: Home Care Provider**

**Evaluator's Name:** Christine Bluhm, RN
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.

**Allegation:**
It is alleged that neglect occurred when facility staff failed to monitor and report the client's changes in condition.

**Investigative Findings and Conclusion:**
Neglect was substantiated. The facility was responsible for the neglect. The facility failed to reassess and monitor the client when the client's ability to eat, drink, and take medications declined. The client was admitted to the hospital with severe dehydration and change in mental status. The client died approximately a week later.

The investigation included interviews with nursing staff and unlicensed staff. The investigation included a review of policies and procedures and staff training records. The investigation included review of several client records, including the client's record and interviews with multiple other clients.

The client's record indicated diagnoses of dementia and a cardiac pacemaker. The client's signed service agreement on admission indicated the client received comprehensive services for full assistance with medication management, with all activities of daily living (ADLs) and housekeeping. The client was completely dependent on staff for feeding and drinking fluids. It indicated the client could transfer and walk with the assistance of one staff member.

Review of the client's service record indicated that unlicensed staff were not always able to provide basic care services when the client had behaviors such as yelling, hitting, or kicking.

The client's care plan indicated behavior management interventions were to reapproach client and reattempt the service. The care plan also indicated staff were to report changes in the client's ability to eat or drink to the nurse.

Review of the nurse practitioner consultation, performed one week after facility admission, indicated that upon exam, the client was alert, calm, cooperative with cares, and she had moist mucous membranes. It indicated a plan to increase Seroquel (an anti-psychotic medication) after speaking to family, monitor behaviors, and have physical, occupational and speech therapy evaluate and treat.

Five days after the consultation, the registered nurse (RN) documented that the client was full care and often resistive to staff with eating and basic ADLs. The same note indicated staff were to reapproach the client. The client's record lacked any further nursing interventions or monitoring of outcomes for the client's behaviors and resistance to care.

Review of the client's medication administration record (MAR) indicated the client was admitted on Seroquel 25 milligrams (mg) three times a day. The MAR indicated that 14 scheduled doses of Seroquel were not given, without a documented explanation. Four days before the client's hospitalization, the Seroquel was increased to 50 mg three times per day.

Review of the facility internal investigation indicated that on the day of the hospitalization, the client did not eat much for lunch. The document indicated that family members had later visited the client for the evening meal and the client refused to eat or drink. It also indicated a family member spoke with the RN by phone about the concerns. After the RN called to speak with staff to obtain more information, it was determined the client was off from her baseline and needed to be evaluated in the emergency room for increased weakness.

Review of the emergency medical services (EMS) documentation indicated emergency responders were dispatched to the facility for a semi-conscious resident. On arrival, they documented the client was only responsive to pain, and they were unable to obtain the client's oxygen saturation, blood pressure or blood glucose readings accurately.

During interview, EMS providers stated the client showed signs of dehydration and the facility staff reported the client had recently refused medications. The EMS provider indicated she was

familiar with the client from previous interactions, and the client's condition was significantly different from those previous interactions. Due to the client's lack of responsiveness, the EMS crew asked about the client's code status and said the facility was unable to provide the information and was unable to confirm the client's full name.

During interview, a management staff member stated the client required staff to feed her, and that could not be completed in the dining room because that environment was too stimulating for the client. This staff member stated she was never told the client had a decline with eating or drinking, and they did not track the client's intake or monitor client's weight.

During an interview, a direct care staff member stated the client's ability to eat and drink had been declining. Staff fed the client in her room, and it usually took one staff member 30-45 minutes to complete a meal.

During interview, the primary family member stated that after the client's admission, he could not visit until after the COVID two-week quarantine period. When finally able to visit, the client was "not herself" and did not eat or drink like her usual. A second family member who was interviewed, stated the concerns of the client's decline as well as other questions, were sent to multiple facility staff with no response. On the day of the hospitalization, the client could not hold her head up to drink. Review of a video from the family's visit on that date appear to show the client having difficulty holding her head up or responding to verbal stimuli.

During interview, the RN stated that on the day of the hospitalization, she requested EMS after speaking with staff and family regarding the client's change in condition. The RN stated that the client's Seroquel had been increased to manage the client's behaviors.

Hospitalization records indicated the client was admitted to the hospital with a diagnosis of severe hypernatremia, dehydration, and abnormal lab values. History and physical details included the resident had severe skin tenting consistent with water deprivation. The client was noted to have skin breakdown on the buttocks with slight ulcerations. Mouth was noted to have dried brown thick scum on teeth and mouth. The client was placed on comfort care and passed away approximately one week later.

In conclusion, 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:
(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. The resident was deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
The facility provided all staff retraining related to reporting changes of behaviors, condition, and food intake, to nursing.

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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cc:
The Office of Ombudsman for Long-Term Care
Steele County Attorney
Ellendale City Attorney
Steele County Sheriff's Office

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H34364 | A. BUILDING: _____ B. WING _____ | C 06/07/2021 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>AMENDED HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On June 7, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL34364003M / HL34364004C. At the time of the investigation, there were # 26 clients receiving services under the comprehensive license.<br><br>The correction orders, tag identification 0355 and 0935, were previously issued on July 30, 2021, for #HL34364003M / HL34364004C.<br><br>On September 24, 2021, MDH issued a determination, based on this investigation, that neglect occurred. These orders are amended by the addition of tag 0325, reflected that finding. No change was made to tags 0355 and 0935 | 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.<br><br>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."<br><br>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<br><br>Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or | 0 325 | | |

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| 0 325 | Continued From page 1<br>in an assisted living facility licensed under chapter 144G has these rights:<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected.<br><br>Findings include:<br><br>On September 24, 2021, 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. The MDH concluded there was a preponderance of evidence that maltreatment occurred. | 0 325 | No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag. | |
| 0 355 SS=D | 144A.44, Subd. 1(a)(20) Contact Individual<br><br>Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights:<br>(20) know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint; | 0 355 | | |

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| 0 355 | Continued From page 2<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to respect the client's right to have the faiclity investigate multiple concerns, including the decline in health status for one of one clients (C1) reviewed.<br><br>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) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>Findings include:<br><br>C1's record was reviewed. C1 had diagnoses of dementia, hypertension, and cardiac pacemaker.<br><br>C1's service plan dated January 11, 2021 indicated the client received services for medication management, full assistance with activities of daily living, meals, feeding and housekeeping.<br><br>Review of email dated February 4, 2021, at 10:29 a.m., sent to Community Director (CD)-H and Health care coordinator (HCC)-B, indicated a list of nine questions regarding C1 that included: the status of pacemaker checks, "relaxer pills" and decreased responsiveness during visits, whether physical and/or occupational therapy had been started, incontinence supplies, request for a copy of the care plan, C1's dining location, was C1 in | 0 355 | | |

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| 0 355 | Continued From page 3<br><br>her room all day, check written and deposit information, and the second round of vaccinations schedule. Specifically, #3 indicated: Medication dosage. (HCC-B), when I stopped in last week to sign the care plan we had visited about how many "relaxer" pills she is given. The doctor prescribed 2-3 pills a day. You said that she is currently getting 3 pills and were looking into increasing the dosage. I'm a little concerned about increasing her dosage as she does not respond much at all. What are your thoughts on that?<br><br>C1 progress note dated February 6, 2021 at 6:24 p.m., indicated C1 had been very lethargic today and not eating or drinking well. This spoke [sic] with daughter and informed of sending into ER to be evaluated.<br><br>During interview on May 27, 2021, at 12:10 p.m., family member (FM)-I stated no response was received from either recipient of her concerns.<br><br>During interview on June 8, 2021, at 3:00 p.m., RN-A stated CD-H should have stepped up and addressed any concerns she could. HCC-B was not available to address the concerns at that time.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 355 | | |
| 0 935 SS=D | 144A.4792, Subd. 8 Documentation of Administration of Medication<br><br>Subd. 8.Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be | 0 935 | | |

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| 0 935 | Continued From page 4<br><br>documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to continue prescribed medication, Seroquel (quetiapine fumarate, antipsychotic medication), for one of one clients (C1) reviewed. Orders were received to increase the order, but the increased order was on hold while family decided on proceeding.<br><br>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) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>Findings include:<br><br>C1's record was reviewed. C1 had diagnoses of dementia, hypertension, and cardiac pacemaker.<br><br>C1's service plan and care plan dated January | 0 935 | | |

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| 0 935 | Continued From page 5<br><br>11, 2021, indicated C1 received comprehensive services and full assistance with medication management, with activities of daily living, meals, feeding and housekeeping. Behavior management interventions were to reapproach client.<br><br>C1 progress note dated January 19, 2021, at 18:30 by health care coordinator (HCC)-B, indicated C1 was seen by NP-K, telehealth, with new orders.<br><br>C1 late entry progress note dated January 25, 2021, by registered nurse (RN)-A, indicated a new order for increased Seroquel was sent to pharmacy. Pharmacy contacted the primary care provider (PCP) for clarification. RN-A spoke to PCP who notified husband and in agreement. Per PCP husband wishing to speak with family before order starts, will inform nursing when ready.<br><br>C1's Medication administration record (MAR) dated January 2021, indicated that C1 did not receive the prescribed Seroquel 25 mg nor the increased dose of 50 mg at the scheduled days/times:<br>January 28 at 8:00 p.m.<br>January 29 at 8:00 a.m., 2:00 p.m., 8:00 p.m.<br>January 30 at 8:00 a.m., 2:00 p.m., 8:00 p.m.<br>January 31 at 8:00 a.m., 2:00 p.m., 8:00 p.m.<br>February 1 at 8:00 a.m., 2:00 p.m., 8:00 p.m.<br>February 2 at 8:00 a.m.<br>Per the MAR, Seroquel 50 mg was restarted on February 2 at 2:00 p.m.<br><br>During interview on July 28, 2021, at 9:40 a.m., ULP-D stated they crushed meds for C1. C1 took her meds ok as long as they were crushed and in applesauce. | 0 935 | | |

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| 0 935 | Continued From page 6<br><br>During interview on July 29, 2021, at 3:17 p.m., RN-A could not provide a physician's order for the 25mg dose to be discontinued or held while waiting for family to decide on the doubled dose of 50 mg. RN-A acknowledged that she told family members that a possible reason for C1's lethargy was that the Seroquel 50 mg dose had reached the 10-day mark on the day C1 was hospitalized. RN-A stated that she now acknowledged that the 50 mg had not been given for the 10 days like she reported to family. RN-A stated she would need to check the provider communication portal to see the communication string. An order to crush the Seroquel was requested. RN-A did confirm that they never received the order to crush the medication.<br><br>Time period for correction: Twenty-one (21) days. | 0 935 | | |