Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL35608001M
Compliance #: HL35608002C

Date Concluded: July 26, 2022

Name, Address, and County of Licensee Investigated:
Heart Group Home LLC
4643 7th St NE
Minneapolis, MN 55421
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident developed a pressure ulcer and had impacted stool in her vaginal canal and rectum.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident developed a pressure ulcer from remaining in the same position for extended periods of time. The facility also failed to provide adequate incontinence care which resulted in multiple urinary tract infections (UTI) and the resident's vaginal canal being impacted with stool.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the contracted home care company staff and the resident's new living facility staff. The investigation included review of the resident's medical record from the facility, hospital, and home care agency. The investigation also included review of facility policies and procedures including vulnerable adult, adverse events, discharges, and staff competency.

The resident resided in an assisted living facility. The resident's diagnoses include quadriparesis (weakness in all four limbs), neurogenic bowel (the loss of normal bowel function due to a nerve problem), and neurogenic bladder (the loss of normal bladder function due to a nerve problem) requiring an indwelling Foley catheter. The resident's service plan included assistance with incontinence care four times daily and as needed, bathing twice weekly, transfers four times daily and as needed, and repositioning four times daily. The resident's assessment indicated the resident's cognitive status as alert and oriented. She used an easy stand for transferring, had an indwelling Foley catheter, and required full assistance from staff with activities of daily living (ADLs). The resident utilized a manual wheelchair that did not tilt backward for relieving pressure.

The resident's service record failed to include catheter care. The service record also failed to include repositioning every two hours and incontinence care every two hours.

The resident also received physical therapy (PT), occupational therapy (OT), and skilled nursing care for her catheter and wounds through a home care agency.

The resident resided at the facility for approximately six months. During this time, the resident developed multiple UTIs and a kidney infection, and she went to the hospital at least five times. The home care agency's skilled nursing and therapy notes indicated the resident also developed a pressure ulcer on her buttock and other forms of skin breakdown on her buttocks and groin.

Approximately three months after the resident admitted to the facility, the facility's nurse (nurse #1) wrote a note indicating the resident had an open wound on her right buttock.

An OT note indicated the resident had a stage 2 pressure ulcer located on her buttock caused by using an improper cushion in her manual wheelchair. The resident told OT the cushion belonged to another resident.

A home care agency nursing note indicated while cleaning the resident, the nurse found dried stool throughout the catheter tubing close to the resident's urethra. This note also indicated the resident reported facility staff had not checked or changed her brief for about four hours.

Approximately six weeks later, the resident presented to the hospital emergency department (ED) with recurrent lethargy. The ED provider note indicated the resident reported her last bowel movement to have occurred three days prior. This note also indicated the ED nurses

attempted bedside irrigation and cleaning, but they continued to find more stool. They then brought her to the shower to wash and irrigate the area again. After the shower, the ED provider performed a pelvic exam to evaluate for a possible rectovaginal fistula (an abnormal passage between the rectum and vaginal canal). At that time, the provider found more stool surrounding the cervix. After another round of irrigation, the provider observed the vaginal canal and found no obvious fistula or entry point for the stool. The ED provider described concern about the care the resident had been receiving at the facility and did not believe the resident was safe for discharge back to the facility due to recurrent, severe drug resistant UTIs. The ED provider note indicated if the stool was being pushed up into the distal vagina by her remaining in soiled briefs, this may be her main risk factor for getting UTIs. The resident spent two days in the hospital. The hospital discharge summary listed the following principal diagnosis: large amount of stool in the vagina secondary to poor hygiene/cares.

A facility nursing note from the day before indicated a home care agency nurse reported the resident appeared sleepy and fatigued. This note did not indicate the facility nurse assessed the resident.

A facility nursing note from the day the resident went to the hospital indicated facility staff reported the resident continued to appear sleepy and fatigued. This note did not indicate the nurse assessed the resident.

Approximately one week later, a home care agency nursing note indicated the resident reported facility staff still did not clean her properly after having bowel movements, even though they had been educated on proper cleaning after a bowel movement to prevent further UTIs.

A PT note from around the same time period indicated the resident had been sitting in her wheelchair for four hours.

Approximately three weeks later, a home care agency nursing note indicated the home care agency nurses found the resident sitting in a brief soiled with stool. Stool also covered a reopened wound on the resident's wound on her right buttock, and perineal area appeared to not have had proper cleaning as evidenced by crusted stool within the resident's pubic hair.

Four days later, a home care agency nursing note indicated stool soiled the resident's wound dressing on her buttock. The resident also developed new skin breakdown on her both of her buttocks that had previously healed, as well as breakdown in the groin that had an odor significant of yeast.

During an interview, nurse #1 stated she assessed the resident's wound many times and deemed it pressure related.

During an interview, an ED nurse (nurse #2) stated she and another nurse attempted to obtain a urine sample in the ED. As they attempted to clean her for the urine sample, they kept cleaning her but continued to find more stool. The doctor ruled out a fissure. She and her colleagues did not know how this could have happened unless the resident had been sitting in her own stool multiple times or for an extended period of time.

During an interview, a home care agency nurse (nurse #3) stated she could only recall one time the resident did not have a stool-soiled brief when she met with the resident. When the resident would sit in her stool, it would get into her vagina. Nurse #3 also stated both pressure and moisture caused the resident's wounds and skin breakdown. The resident relied on the facility staff to turn and reposition her, and she sat in a particular position often. She stated nurses from the home care agency completed education with facility staff, but the resident continued to experience skin breakdown.

During an interview, the resident stated the wounds and skin breakdown were due to laying or sitting in one position and stool remaining in her brief. Transferring with an easy stand required the assistance of two staff members, but sometimes only one staff worked at a time, so she could not transfer into her wheelchair. When the resident asked staff for assistance with transferring or incontinence care, she had to wait about an hour. The resident stated staff wanted to keep her in bed and were reluctant to complete their duties. The resident stated the staff would not clean her perineal area and would sometimes go three weeks without a shower. The resident also stated the emergency room staff confirmed her UTIs were being caused by poor hygiene.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No; the resident is her own responsible party.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility nurse completed skin checks on the resident. The nurse educated staff on perineal care and the use of barrier cream for incontinence.

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, 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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Columbia Heights City Attorney
Columbia Heights Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35608	A. BUILDING: _____ B. WING _____	C 06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART GROUP HOME	4643 7TH STREET NE COLUMBIA HEIGHTS, MN 55421

(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 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: #HL35608002C/#HL35608001M On June 17, 2022, 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 four (4) residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL35608002C/#HL35608001M, tag identification 0740, 2360.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 740 SS=F	144G.43 Subd. 4 Transfer of resident records With the resident's knowledge and consent, if a	0 740		

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0 740	Continued From page 1 resident is relocated to another facility or to a nursing home, or if care is transferred to another service provider, the facility must timely convey to the new facility, nursing home, or provider: (1) the resident's full name, date of birth, and insurance information; (2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any; (3) the resident's current documented diagnoses that are relevant to the services being provided; (4) the resident's known allergies that are relevant to the services being provided; (5) the name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided; (6) all medication administration records that are relevant to the services being provided; (7) the most recent resident assessment, if relevant to the services being provided; and (8) copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to send all necessary medical information to an admitting licensee upon discharge from the licensee for one of one (R1) resident records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 740		

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0 740	Continued From page 2 of the residents). The findings include: R1's diagnoses included quadriparesis, neurogenic bowel, and neurogenic bladder with chronic indwelling Foley catheter. R1's signed service agreement dated November 15, 2021, indicated R1 received services including medication administration, blood glucose monitoring, and incontinence care. During an interview on June 24, 2022 at 11:02 a.m., registered nurse (RN)-A stated the licensee's discharge process did not include obtaining discharge orders, and the responsibility fell on the admitting licensee. RN-A stated the licensee provided the admitting licensee the contact information for the resident's primary care provider, so the admitting licensee could contact the provider. The licensee's process for discharging a resident included the case manager (CM) finding placement. Once the CM found placement and set up a discharge date, the admitting licensee obtained orders to receive the resident to their facility. RN-A stated if the admitting licensee would have made it clear they needed signed physician orders, she would have called the provider. During an interview on June 29, 2022 at 2:39 p.m., RN-I stated she requested the licensee fax all necessary discharge paperwork, including signed orders, prior to R1 discharging the licensee, and to send hard copies with her. The licensee stated they were working on the discharge. R1 arrived at the admitting licensee on May 10, 2022 between approximately 12:00 p.m. and 1:00 p.m. with a copy of her medication administration record (MAR), service plan, and	0 740		

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0 740	Continued From page 3 discharge summary. The licensee did not send any paperwork signed by a physician, including discharge, medication, catheter care, and wound care orders. RN-I stated she attempted multiple times to obtain the signed orders but instead of sending physician-signed orders, RN-A signed and re-faxed the same paperwork the admitting licensee obtained from R1. After two days, RN-I had to send R1 to the emergency department to obtain signed physician orders and get her blood glucose level under control. RN-I stated if the licensee would have asked for help in obtaining orders, she would have reached out to the provider herself. Email correspondence from RN-I to the licensee and CM-F on April 27, 2022 at 11:15 a.m. licensee indicated RN-I needed orders from R1's current provider approving her to discharge from the licensee, R1's medications to continue for thirty (30) days past her discharge, and an updated service plan to be sent with her. RN-I also requested to have these documents one day prior to discharge as well as have hard copies sent with R1. Email correspondence from CM-F to the licensee on May 10, 2022 at 4:08 p.m., indicated CM-F informed the licensee the admitting licensee did not receive any physician orders, including medication orders and wound care orders. CM-F instructed the licensee needed to send the orders to RN-I as soon as possible, or R1 may need to go to the hospital. Email correspondence on May 10, 2022 at 5:40 p.m. indicated the licensee informed CM-F they thought the admitting licensee had to obtain the orders from the provider, noting the licensee does not have their own provider, so residents use	0 740		

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0 740	Continued From page 4 their own provider. Discharge paperwork sent with R1 to the admitting licensee included an unsigned list of R1's current medications, a diagnosis list, discharge summary, care plan, notes, and hospital paperwork from her March 26, 2022 hospitalization. The licensee's policy titled Discharge and Transfer of Residents, effective date August 1, 2021, indicated the licensee would, at the request of the resident or resident's representative, take steps to ensure a coordinated discharge. TIME PERIOD FOR CORRECTION: Seven (7) days	0 740		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 5 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to include catheter care on the service plan, as well as implement areas of the service plan including incontinence care and repositioning for one of one residents (R1) with record review. 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 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 hemiparesis and neurogenic bowel. R1's signed service agreement dated November 15, 2021, indicated R1 received incontinence care four times per day and as needed (PRN) and repositioning four times per day. A nursing assessment dated February 27, 2022 indicated the resident required assistance with turning and repositioning, transferring, and perineal care. This assessment indicated staff would reposition R1 every four hours, transferring her if needed. This assessment also indicated R1 required assistance with catheter care and bowel	01640		

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01640	Continued From page 6 incontinence. R1 also received services through a home care agency including catheter changes monthly and wound care. R1's signed service agreement dated November 15, 2021 failed to include catheter care. A home care agency nursing note dated February 18, 2022 at 11:06 a.m., indicated dried stool covered R1's catheter tubing close to her urethra. R1 reported licensee staff had not checked or change her brief since 7:00 a.m. R1's March 2022 service summary indicated staff consistently signed off on incontinence care at an unspecified time in the morning, 6:00 p.m., 8:00 p.m., and 10:00 p.m. R1's hospital medical record indicated she went to the emergency department (ED) on March 26, 2022 for lethargy. When attempting to perform perineal care to obtain a urine sample, ED nurses had to irrigate the resident's vaginal canal multiple times and give her a shower. After this, the physician irrigated her vaginal canal and still found impacted stool up to the cervix. R1 admitted to the hospital with a diagnosis of large amount of stool in vagina secondary to poor hygiene/cares. R1's April 2022 service summary also indicated staff consistently signed off on repositioning at unspecified times at midday, evening, bedtime, and overnight. During an interview on June 17, 2022 at 2:37 p.m., unlicensed personnel (ULP)-B stated staff repositioned R1 every two hours, but R1 liked to lay flat and did not like being repositioned.	01640		

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01640	Continued From page 7 During an interview on June 4, 2022 at 9:02 a.m., registered nurse (RN)-E stated she and another nurse attempted multiple times to clean R1 in the ED, but feces continued to come out of her vaginal canal. RN-E stated she and her colleagues did not know how so much stool could have been impacted up her vaginal canal to her cervix without either sitting in her own stool for various times or an extended period of time. During an interview on June 24, 2022 at 11:02 a.m., RN-A stated staff were to check and change R1 every two hours. RN-A also stated pressure caused the wound on her buttock. During an interview on June 28, 2022 at 10:09 a.m., R1 stated the licensee staff did not check and change, toilet, or reposition her every two hours like they were supposed to. Staff would only come to check her when she asked, and she often had to wait about an hour for the assistance. TIME PERIOD FOR CORRECTION: Seven (7) Days	01640		
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 interview and document review, the licensee failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected.	02360	There is no plan of correction required for tag 2360. Please refer to the public maltreatment report (sent separately) for details.	

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02360	Continued From page 8 Findings include: On July 26, 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		