Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Interim HC of the Twin Cities
2833 North Fairview Avenue
Roseville, MN 55113
Ramsey County

Report #: H7104010

Date: September 8, 2014

Date of Visit: August 15 & 21, 2014
Time of Visit: 8:30 a.m. – 3:00 p.m.
1:00 p.m. – 3:00 p.m.

By: Deborah Neuberger, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☒ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): It is alleged that a patient was neglected when a staff member, alleged perpetrator, (AP) failed to seek medical attention when the patient had a change in condition. The patient was admitted to the hospital with severe ulcers all over his/her bottom and weighed only approximately 80 pounds.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☒ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)

☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☐ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect is substantiated. Although a registered nurse visited the patient on a weekly basis, the nurse failed to adequately assess, identify and intervene for the patient's declining condition. The agency who employed the nurse failed to provide supervision and oversight.

The patient was referred to the agency in 2012 with a primary diagnosis of failure to thrive and Parkinson's disease. The patient had a referral for skilled nurse visit one time a week for medication management and home safety evaluation. The most recent skilled nurse visit note revealed the patient complained of recent poor appetite. Although vital signs were recorded, no assessment of the patient's weight or any other objective measure of nutritional status was recorded.

The agency comprehensive assessment included an area to record the patient's weight, vital signs, and a nutritional risk assessment. The patient's most recent comprehensive assessment dated 5/2/2014 revealed that the patient was not weighed as part of the comprehensive assessment, despite failure to thrive being the primary diagnosis. A review of all of the patient's comprehensive assessments since the patient's admission in 2012 revealed no weight monitoring was completed as part of the patient's every 60 day comprehensive assessments.

The patient's hospital record revealed the patient was admitted to the hospital's emergency department on 7/1/2014 with diagnoses including multi-system atrophy and profound malnutrition. The patient's discharge summary revealed the patient weighed about 80 pounds at admission. The patient was profoundly underweight with very large pressure ulcer and a severe blood infection. The patient was placed on a ventilator. The patient was weaned from the ventilator on 7/2/2014 and placed on hospice. S/he died on 7/15/2014.

During an interview, the alleged perpetrator (AP) stated the patient had been his/her patient since 2012. The AP stated s/he checked the patient's nutritional status by looking at the patient and checking for food in the home. The AP stated she did not ever weigh the patient despite his diagnosis of failure to thrive and concerns about his/her difficulty swallowing because the patient had no scale. The AP stated she checked the patient's skin at the time of the comprehensive assessment on 5/2/2014, and s/he had no open areas. The AP stated no skin check was done at his/her last skilled nurse visit 6/24/14. The AP stated she offered the patient the opportunity to go to a nursing home at some point in the last 2 years, but the patient wanted to stay in his/her own home. The AP stated s/he did not document any conversations about the risk of self-neglect, nor did s/he inform the

patient's physician about self-neglect concerns regarding the patient. The AP stated s/he did not know the patient had lost weight or had wounds.

The Administrative Nurse stated s/he became aware of the concern related to the patient's home health care when the hospital called the agency. The administrative nurse stated that the agency conducts interdisciplinary team (IDT) meetings in which staff nurses discuss their patients who are at risk in any area, but the AP does not participate in the IDT meetings.

During an interview, the patient's primary physician stated s/he had not seen the patient since June 2013. At that time, there were concerns related to a decreased nutritional intake and a nutrition consult was ordered. At the time of the nutrition consult in 2013, the patient weighed 105.5 pounds and had difficulty swallowing. The physician stated he would expect that weights would be monitored on a patient who was at risk for nutrition problems. The physician stated his office did not get any calls concerning the patient's weight or concerns for self-neglect for the patient at home.

A review the patient's death certificate revealed the patient's cause of death listed as Aspiration Pneumonia and Multi-system Atrophy.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The agency policy and practice included yearly performance evaluations and IDT meetings to monitor patient care. No performance evaluation since 2/2010 could be located for the AP. The AP did not participate in IDT meetings with administrative staff. The facility failed to provide adequate caregiver supervision.

Although the AP was a Registered Nurse, the AP failed to follow the nursing process when s/he failed to thoroughly assess, identify and intervene for a significant change in patient condition.

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.

Compliance:

Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) – Compliance Not Met
The requirements under Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484) were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____

(The 2567 will be available on the MDH website.)

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"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.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☐ Medication Administration Records
- ☒ Treatment Sheets
- ☒ Facility Incident Reports
- ☒ Physician Progress Notes
- ☐ ADL (Activities of Daily Living) Flow Sheets
- ☐ Laboratory and X-ray Reports
- ☒ Physician Orders
- ☐ Social Service Notes
- ☒ Nurses Notes
- ☐ Meal Intake Records
- ☐ Activities Reports
- ☒ Weight Records
- ☐ Therapy and/or Ancillary Services Records
- ☒ Assessments
- ☒ Skin Assessments
- ☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate

☐ Police Report

Additional facility records:

- ☐ Resident/Family Council Minutes
- ☒ Personnel Records/Background Check, etc.
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility In-service Records
- ☒ Facility Internal Investigation Reports
- ☒ Facility Policies and Procedures
- ☐ Call Light Audits
- ☐ Other, specify: _____

Number of additional resident(s) reviewed: 17

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: He was deceased.

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 2

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 4

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☒ Other: Specify Hospital Social Worker.

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☐ Facility Tour
☒ Infection Control	☒ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Nursing
Ramsey County Medical Examiners
Roseville City Police Department
Ramsey County Attorney
Roseville City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	247104	A. BUILDING _____ B. WING _____	C 08/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERIM HEALTHCARE OF THE TWIN CITIES	2833 NORTH FAIRVIEW AVENUE ROSEVILLE, MN 55113

(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) COMPLETION DATE
G 000	INITIAL COMMENTS A partial extended survey was conducted related to the investigation for #H7104010 to investigate an alleged violation of the Conditions of Participation for Home Health Agencies. Condition level deficiencies were identified at 42 CFR 484.55 the Condition of Comprehensive Assessment of Patients (refer to tag G338). Interim Healthcare of the Twin Cities is precluded from conducting home health aide training and/or competency evaluation for a period of two years beginning 8/25/14. Federal Law as specified in 42 CFR 484.36 (a)(2), prohibits any home health agency to offer and or conduct home health aide training and/or competency testing which, within the previous two years has been subject to a partially extended survey as a result of having been found to have a Federal Condition of Participation not met at partially extended survey.	G 000		
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on interview and document review the Administrator failed to ensure the agency employed personnel with adequate annual performance evaluations for 3 of 13 employees reviewed, Registered Nurse (RN)-C, RN-J and	G 134	G134 484.14(c) **To remedy the current situation:** A) The HR Manager will audit the employee records by September 22, 2014 for all active employees to determine who have not had at least one of the following two items within the past 12 months: • Annual Performance Evaluation • On-site employee supervisory visit "Employee Performance Supervision Report". The HR Manager will direct the supervisors of the employees without the required evaluations to complete an evaluation by October 6, 2014. The Director of Nursing terminated RN C on 8-26-14 and was also reported to MN Board of Nursing per their Complaint Information Reporting procedure.	10/6/14 8/26/14

RECEIVED
SEP 25 2014
OHFC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Pamela Halverson Administrator/C.O.O. 9-24-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 134	Continued From page 1 RN-K, who had not had a performance evaluation in the last year. RN-C failed to adequately assess and monitor P-1 for nutritional risk and P-1 was admitted to the hospital severely malnourished. Findings include: Employee personnel records were reviewed for performance evaluations. RN-C's date of hire was 12/29/2008. The most recent performance review was dated 2/2010, more than 4 years prior to the investigation. P-1's Community Home Care referral dated 5/7/2012 was reviewed and revealed a request for Skilled Nurse Visit one time weekly for medication management and home safety evaluation, including a request for the home health nurse to monitor his medications and overall safety at least weekly. P-1's hospital record, admission dated 7/1/2014, was reviewed and revealed P-1 was admitted to the hospital's emergency department on 7/1/2014 with diagnoses including multi-system atrophy, and profound malnutrition. P-1's discharge summary dated 7/15/2014 was reviewed and revealed P-1 weighed about 80 pounds at admission. P-1 was noted to be profoundly emaciated with very large sacral decubiti and severe sepsis. P-1 was found covered in feces and urine. P-1 was placed on a ventilator. P-1 was weaned form the ventilator on 7/2/2014 and placed on hospice. P-1 died on 7/15/2014. Registered Nurse C (RN-C) was interviewed on 8/20/2014 at 11:00 a.m. and stated P-1 had been her patient since 2012. RN-C stated P-1 had diagnoses that included Parkinson's and Failure	G 134	**To ensure employment of competent clinicians:** On 9/19/14 the HR Manager implemented the following process: • Enter the schedules of performance evaluations for each employee into the computer system • Run performance evaluation report monthly to identify employees who are due for performance evaluations within the next 30 days. • Notify appropriate supervisors of pending performance evaluations • Upon hire ensure all clinicians are assessed for competency prior to initial assessment via knowledge exams, Skills Checklists. **Monitoring the effectiveness of the process:** The HR Manager • Monthly compiles data regarding performance evaluations • Monthly reviews records of employees hired within the last 30 days regarding the presence of new hire competency testing • Reports summary and detail of findings to the Director of Nursing and the Therapy Director monthly • The Director of Nursing and the Therapy Director tracks compliance to performance evaluations and new hire competency testing monthly ongoing. RECEIVED SEP 25 2014 OHFC	9/19/14

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G 134	Continued From page 2	G 134		

to Thrive. RN-E stated she checked P-1's nutritional status by looking at the patient and checking that there was food in the home and P-1 seemed to be about the same according to these criteria. RN-C stated she did not ever weigh P-1 despite his diagnosis of Failure to Thrive and concerns about his difficulty swallowing, because P-1 had no scale. RN-C stated she did not attempt to get a scale for P-1. RN-C stated she did not know P-1 had lost weight and therefore did not report that to P-1's physician.

Director of Nursing B (DON-B) was interviewed on 8/15/2014 at 12:00 p.m. and stated that a patient with Failure to Thrive as a diagnosis should be having his weight monitored by the home health agency nursing staff as part of his nursing assessments. DON-B stated that the agency has interdisciplinary team (IDT) meeting in which staff nurses discuss their patients who are at risk in any area, but RN-C does not participate in the IDT meetings, so administrative staff were not aware of any concern related to P-1's condition. DON-B stated she was RN-C's supervisor, but she had not supervised RN-C during a skilled nurse visit. DON-B stated the last performance evaluation for RN-C was in 2/2010.

RN-J's date of hire was 3/16/2010. No performance review could be located for this employee.

RN-K's date of hire was 4/2/2010, The most recent performance review was dated 1/10/2012, more than two years prior to the investigation.

When the agency policy regarding performance review of agency staff was requested, DON-B stated on 8/21/2014 at 1:30 p.m. that the agency

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G 134	Continued From page 3 practice is to perform performance reviews annually.	G 134		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on interview and document review the agency registered nurse failed to initiate the plan of care and necessary revisions for 1 of 18 patient reviewed, Patient #1, (P-1), who was at nutritional risk, but agency staff failed to accurately assess, monitor and revise the plan of care. Findings include: P-1's client order document dated 5/7/2012 was reviewed and revealed the patient was referred to the agency on 5/7/2012 with a primary diagnosis of Failure to Thrive and Parkinson's Disease. P-1's Community Home Care referral dated 5/7/2012 was reviewed and revealed a request for Skilled Nurse Visit one time weekly for medication management and home safety evaluation, including a request for the home health nurse to monitor his medications and overall safety at least weekly. P-1's referral included aspiration precautions. A hospital progress note sent with the referral dated 4/12/2012 and provided by the agency revealed P-1 had a speech evaluation while hospitalized with results indicating P-1 had delayed chewing and recommending a mechanically altered diet.	G 173	G173: 484.30 (s) DUTIES OF A REGISTERED NURSE: The registered nurse initiates the plan of care and necessary revisions. **To remedy the current situation:** 1. By 8/22/14 all of RN-C's patients were contacted and/ or visited by the Director of Nursing or another RN Case Manager to: • Provide a comprehensive assessment of the patient's current condition • Review the current Plan of Care (POC) to ensure all patient needs are being addressed • Ensure that standards of practice are being followed • All patients were found to be safe, in no distress and having their needs met appropriately 2. The Director of Nursing terminated RN C on 8/26/14 and a report was made to the Board of Nursing. 3. The Director of Nursing reassigned all patients of RN C to other nurses by 8/26/14. • The current assessment findings were shared with each nurse • The current POC was reviewed with each nurse 4. All clients identified with the following diagnoses; Failure to Thrive, Parkinson's, decubitus ulcer and sepsis were audited to assure appropriate plan of care. • The reports of those audits were reviewed with the supervisor and follow up was done with the clinician responsible for the case as needed.	8/22/14 8/26/14

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G 173	Continued From page 4 P-1's initial start of care assessment, dated 5/16/2012 was reviewed. Despite P-1's admission diagnosis of Failure to Thrive, the assessment did not include an assessment of P-1's weight. Despite the recommendation of a mechanically altered diet, a regular diet was utilized. Despite the speech evaluation revealing P-1 had delayed chewing, this was not included in the initial assessment of the patient. An blank agency comprehensive assessment was reviewed. The assessment included an area to record the patient's weight, vital signs, and a nutritional risk assessment. The nutritional risk assessment included an assessment of the patient's appetite, diet, fluid restrictions, supplement use, use of a tube for feeding, conditions relating to the kind and/or amount of food consumed, how many meals a day a patient consumes, what types consumed, (vegetables, dairy, etc.) how many alcoholic beverages consumed, mouth problems, financial issues, who the patient eats with, how many medications the patient takes, if the patient has lost weight, and if the patient is able to cook his/her own food. P-1's most recent Recertification (comprehensive) Assessment dated 5/2/2014 was reviewed and revealed that although the nutritional assessment area indicates the need to assess the patient's weight as part of the assessment, P-1 was not weighed as part of the comprehensive assessment, despite failure to thrive being the primary diagnosis. Section 61, nutritional screening revealed the staff member left blank the patient's weight, left blank question 1 "Patient has an illness or condition that changes the kind and/or amount of food consumed." and	G 173	**To ensure that clinicians provide accurate assessment, monitoring and revisions to the plan of care ongoing:** 1. On 9-24-14, the Director of Nursing and the Director of Therapy conducted training for the clinicians to address the following requirements: • All fields of the comprehensive assessment must be completed including all vital signs and weights • A comprehensive assessment includes a review of the patient's previous history as available on the History and Physical and the facility Discharge Summary • Patients at risk for a nutritional deficit must have a POC that addresses specific interventions regarding nutrition. • Patients at risk for developing a pressure ulcer (Refer to Braden Scale) must have their skin assessed at every visit • Patients at risk for developing pressure ulcers must have a POC that addresses specific interventions regarding prevention of pressure ulcers • Patients at risk for falls must have a POC that addresses specific interventions regarding fall prevention • Clinician's must notify the patient's physician for all changes in patient's condition and document the conversation in the patient record. • Clinicians must notify the supervisor for all changes in the patient's condition • Review of the policy "Evaluating the Effectiveness of the Plan of Care / Service Plan". 2. As of 9-22-14 the expectations outlined were incorporated into the Clinical Orientation Program by the Director of Nursing and the Director of Therapy.	9/24/14 9/22/14

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	247104	A. BUILDING _____ B. WING _____	C 08/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERIM HEALTHCARE OF THE TWIN CITIES	2833 NORTH FAIRVIEW AVENUE ROSEVILLE, MN 55113

(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) COMPLETION DATE
G 173	Continued From page 5 left blank "Patient lost or gained 10 pounds in the last 6 months" despite P-1 having a condition that changes the kind and amount of food consumed, documented swallowing problems and despite the staff member not weighing the patient. A review of all of P-1's comprehensive assessments since P-1's admission in 2012 revealed no weight monitoring being completed as part of P-1's every 60 day comprehensive assessments. No updates/revisions to the plan of care were completed by agency staff related to P-1's weight loss, as it was not being documented. P-1's hospital record, admission dated 7/1/2014, was reviewed and revealed P-1 was admitted to the hospital's emergency department on 7/1/2014 with diagnoses including multi-system atrophy, and profound malnutrition. P-1's discharge summary dated 7/15/2014 was reviewed and revealed P-1 weighed about 80 pounds at admission. P-1 was noted to be profoundly emaciated with very large sacral decubiti and severe sepsis. P-1 was found covered in feces and urine. P-1 was placed on a ventilator. P-1 was weaned form the ventilator on 7/2/2014 and placed on hospice. P-1 died on 7/15/2014. Registered Nurse C (RN-C) was interviewed on 8/20/2014 at 11:00 a.m. and stated P-1 had been her patient since 2012. RN-C stated P-1 had diagnoses that included Parkinson's and Failure to Thrive. RN-E stated she checked the patient's nutritional status by looking at the patient and checking that there was food in the home and P-1 seemed to be about the same according to these criteria. RN-C stated she did not ever weigh P-1 despite his diagnosis of Failure to Thrive and concerns about his difficulty swallowing because	G 173	3. Effective 9-22-14, the supervisor of the assessing clinician will: • Review each SOC assessment and each Follow Up assessment for completeness and accuracy • Review the proposed POC to ensure that the patient's needs/ problems identified on the assessment are addressed on the POC • Track and trend the findings of each review • One on one counseling will be done with Clinicians needing improvement with assessment and documentation • Forward the tracking / audit forms to the Administrator weekly 4. Weekly Case Conferences are held to discuss every client admitted in the previous 14 days with a review of the Plan of Care. **Monitoring the effectiveness of the process:** 1. The Administrator will review the tracking and trending spreadsheet weekly. 2. The Administrator will continue to review the tracking and trending results weekly until results demonstrate 100% compliance for 3 consecutive weeks, and then will review results quarterly. 3. Clients with no improvement in wound healing within two weeks of start of care will have the physician notified to discuss treatment options.	

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G 173	Continued From page 6 P-1 had no scale. RN-C stated she did not attempt to get a scale for P-1. RN-C stated she did not know P-1 had lost weight and therefore did not report that to P-1's physician. No update to the plan of care was initiated. P-1's primary physician, (MD-E) was interviewed on 8/22/2014 at 10:45 a.m. and stated he had not seen P-1 since June, 2013, one year earlier. At that time there were concerns with decreased nutritional intake and a nutrition consult was ordered. At the time of the nutrition consult in 7/2013 P-1 weighed 105.5 pounds and had difficulty swallowing. MD-E stated he would expect that weights would be monitored on a patient who was at risk for nutrition problems as P-1 was. MD-E stated his physician's office did not get any calls concerning P-1's weight or concerns for self-neglect for the patient at home. MD-E stated that if the office did receive a call regarding weight loss and/or P-1 refusing further intervention, the next step would be to have a discussion with the patient regarding risks of decreased nutrition and refusal of interventions. Director of Nursing B (DON-B) was interviewed on 8/15/14 at 12:00 p.m. and stated that a patient with Failure to Thrive as a diagnosis should be having his weight monitored by the home health agency nursing staff. DON-B stated that the agency has interdisciplinary team (IDT) meeting in which staff nurses discuss their patients who are at risk in any area, but RN-C does not participate in the IDT meetings, so administrative staff were not aware of any concern related to P-1's condition. DON-B stated she was RN-C's supervisor, but she had not supervised RN-C during a skilled nurse visit.	G 173		

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G 173	Continued From page 7 The policy titled Evaluating the Effectiveness of the Plan of Care/Service Plan dated 8/27/04 and provided by the agency was reviewed and the following was noted: At Each Encounter 1. The designated employee determines the effectiveness of the plan of care/service plan at each encounter by comparing the patient's current status against the established goals. C) If the patient's current status does not demonstrate expected progress towards established goals, the designated employee: i) Consults with their supervisor and the health care practitioner and/or other responsible party to revise the plan of care/service plan.	G 173		
G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary	G330	G330 484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS **To remedy this situation:** 1. RN –C was terminated from the agency on 8-26-14 and reported to the Board of Nursing. 8/26/14 2. Documentation requirements were reviewed with all clinicians during the clinical meetings the week of September 24, 2014, with emphasis on accurate completion of Comprehensive Assessments: 9/24/14 • No areas on the form are to be left blank • Weights and vital signs are to be included. • Nutritional and skin assessments are to be done. • All abnormal findings are to be reported to the physician, documented when the report was made and change in plan of care is implemented as ordered. 3. To remedy situations where clinicians are caring for individuals living in unsafe situations, refusing to go to nursing homes or assisted living facilities or accepting additional help such as home health aide or PCA: • Vulnerable adult retraining was done for all clinicial staff, the week of September 24, 2014 by the Director of Nursing and the Director of Therapy.	

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G 330	Continued From page 8 This CONDITION is not met as evidenced by: Based on interview and document review the agency failed to provide an accurate comprehensive assessment according to patient needs reflecting the patient's current health status for 1 of 18 patients reviewed Patient #1 (P-1), who was at risk for weight loss, experienced significant weight loss and the agency failed to adequately assess and identify changes in the patient's condition. The seriousness of the systems problems resulted in the agency's inability to maintain effective comprehensive assessment services. Therefore the agency was unable to meet the Condition of Participation of Comprehensive Assessment of Patients 42 CFR 484.55. This deficient practice had the potential to impact 18 patients receiving services from the agency. See tag G338. Based on interview and document review the agency failed to update and revise the comprehensive assessment as frequently as the patient's condition warrants due to a major decline in the patient's health status for 1 of 18 patients reviewed, Patient #1 (P-1), who experienced a significant weight loss, and the agency failed to adequately assess, monitor and intervene for the patient's condition. Findings include:	G 330	**To ensure that clinicians provide accurate assessment:** 1. The Director of Nursing will assign a co-RN to any client on service for greater than 60 days to alternate assessments with the current Case Manager. 2. The supervisors of the assessing clinicians will review the SOC, ROC and Recert assessments and completing the audit tracking forms. • One on one counseling by the supervisors will be done with any clinician needing improvement in assessing and documentation. 3 To ensure that clinicians know how to recognize unsafe situations: • Retraining of clinicians the week of September 24, 2014 emphasized how to handle clients who are noncompliant with plan of care and/or choosing to live in unsafe situations, with emphasis on reviewing warning signs of inadequate or no food, heat or cooling for reasonable daily comfort. • The MSW attends all weekly Care Conferences to further evaluate and assist in obtaining additional support for clients in unsafe situations **To monitor the effectiveness of this:** • The Administrator will review the weekly audit tools from the supervisors. • The Administrator will continue to monitor weekly until there are three consecutive weeks of compliance. • Supervisors will work with Clinicians who identify unsafe or uncooperative client situations so appropriate steps can be made with the county and physician to implement a safe plan for the client.	9/24/14
G 338	484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.	G 338	G338: **To remedy this situation:** 1. RN –C was terminated from the agency on 8-26-14 and reported to the Board of Nursing.	

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G 338	Continued From page 9 This STANDARD is not met as evidenced by: Based on interview and document review the agency failed to update and revise the comprehensive assessment as frequently as the patient's condition warrants due to a major decline in the patient's health status for 1 of 18 patients reviewed, Patient #1 (P-1), who was at nutritional risk, experienced a significant weight loss, and the agency failed to adequately assess, monitor and intervene for the patient's condition. Findings include: P-1's client order document dated 5/7/2012 was reviewed and revealed the patient was referred to the agency on 5/7/2012 with a primary diagnosis of Failure to Thrive and Parkinson's Disease. P-1's Community Home Care referral dated 5/7/2012 was reviewed and revealed a request for Skilled Nurse Visit one time weekly for medication management and home safety evaluation, including a request for the home health nurse to monitor his medications and overall safety at least weekly. P-1's referral included aspiration precautions. A hospital progress note sent with the referral dated 4/12/2012 and provided by the agency revealed P-1 had a speech evaluation while hospitalized with results indicating P-1 had delayed chewing and recommending a mechanically altered diet. P-1's Home Health Certification and Plan of Care dated 5/6/2014 - 7/4/2014 was reviewed and revealed the patient had physician's orders to receive skilled nurse visits 1 time per week. Under the section comments the following was	G 338	2. Documentation requirements were reviewed with all clinicians during the clinical meetings the week of September 24, 2014, with emphasis on accurate completion of Comprehensive Assessments: • No areas on the form are to be left blank • Weights and vital signs are to be included. • Nutritional and skin assessments are to be done. • All abnormal findings are to be reported to the physician, documented when the report was made and change in plan of care is implemented as ordered. 3. To remedy situations where clinicians are caring for individuals living in unsafe situations, refusing to go to nursing homes or assisted living facilities or accepting additional help such as home health aide or PCA: • Vulnerable adult retraining was done for all clinicial staff, the week of September 24, 2014 by the Director of Nursing and the Director of Therapy. To ensure that clinicians provide accurate assessment: 1. The Director of Nursing will assign a co-RN to any client on service for greater than 60 days to alternate assessments with the current Case Manager. 2. The supervisor of the assessing clinicians will review the SOC, ROC and Recert assessments and completing the audit tracking forms. • One on one counseling by the supervisors will be done with any clinician needing improvement in assessing and documentation.	9/24/14 9/24/14

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G 338	Continued From page 10 noted: "Client is a 66 year old client with diagnosis of failure to thrive, COPD (chronic obstructive pulmonary disease) and Parkinson's Disease. Lives in apartment has neighborhood friend who assists as needed. Appetite remains fair swelling improved in lower extremity, remains alert and oriented, remains incontinent of bladder, manages with depends skin remains in tact, receives skilled nurse visits 1 time a week for medication set up and assessment remains compliant with medication administration. Plan: skilled nurse visit 1 time a week." The most recent skilled nurse visit note dated 6/25/2014 was reviewed and revealed P-1 complained of recent poor appetite. Although vital signs were recorded, no assessment of the patient's weight or any other objective measure of nutritional status was recorded. The agency comprehensive assessment was reviewed. The assessment included an area to record the patient's weight, vital signs, and a nutritional risk assessment. The nutritional risk assessment included an assessment of the patient's appetite, diet, fluid restrictions, supplement use, use of a tube for feeding, conditions relating to the kind and/or amount of food consumed, how many meals a day a patient consumes, what types consumed, (vegetables, dairy, etc.) how many alcoholic beverages consumed, mouth problems, financial issues, who the patient eats with, how many medications the patient takes, if the patient has lost weight, and if the patient is able to cook his/her own food. P-1's most recent Recertification (comprehensive) Assessment dated 5/2/2014 was reviewed and revealed that although the	G 338	3 To ensure that clinicians know how to recognize unsafe situations: • Retraining of clinicians the week of September 24, 2014 emphasized how to handle clients who are noncompliant with plan of care and/or choosing to live in unsafe situations, with emphasis on reviewing warning signs of inadequate or no food, heat or cooling for reasonable daily comfort. • The MSW attends all weekly Care Conferences to further evaluate and assist in obtaining additional support for clients in unsafe situations **To monitor the effectiveness of this:** 1. The Administrator will review the weekly audit tools from the supervisors. 2. The Administrator will continue to monitor weekly until there are three consecutive weeks of compliance. 3. Supervisors will work with Clinicians who identify unsafe or uncooperative client situations so appropriate steps can be made with the county and physician to implement a safe plan for the client.	

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G 338	Continued From page 11 nutritional assessment area indicates the need to assess the patient's weight as part of the assessment, P-1 was not weighed as part of the comprehensive assessment, despite failure to thrive being the primary diagnosis. Section 61. nutritional screening revealed the staff member left blank the patient's weight, left blank question 1 "Patient has an illness or condition that changes the kind and/or amount of food consumed." and left blank "Patient lost or gained 10 pounds in the last 6 months" despite P-1 having a condition that changes the kind and amount of food consumed, documented swallowing problems and despite the staff member not weighing the patient. A review of all of P-1's comprehensive assessments since P-1's admission in 2012 revealed no weight monitoring being completed as part of P-1's every 60 day comprehensive assessments. P-1's hospital record, admission dated 7/1/2014, was reviewed and revealed P-1 was admitted to the hospital's emergency department on 7/1/2014 with diagnoses including multi-system atrophy, and profound malnutrition. P-1's discharge summary dated 7/15/2014 was reviewed and revealed P-1 weighed about 80 pounds at admission. P-1 was noted to be profoundly emaciated with very large sacral decubiti and severe sepsis. P-1 was found covered in feces and urine. P-1 was placed on a ventilator. P-1 was weaned form the ventilator on 7/2/2014 and placed on hospice. P-1 died on 7/15/2014. Hospital Social Worker G, (SW-G) was interviewed on 8/20/2014 at 10:00 a.m. and stated P-1 was admitted to the hospital on 7/1/2014. P-1 was unresponsive and severely emaciated upon admission. P-1 was intubated on	G 338		

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G 338	Continued From page 12 7/1/2013 and tube feedings were started on 7/3/2014. On 7/2/2014 P-1 was weighed and found to be 35 Kg. (77 pounds). SW-G stated she has never seen a human being in such bad shape as P-1 was upon admission to the hospital. Registered Nurse C (RN-C) was interviewed on 8/20/2014 at 11:00 a.m. and stated P-1 had been her patient since 2012. RN-C stated P-1 had diagnoses that included Parkinson's and Failure to Thrive. RN-E stated she checked the patient's nutritional status by looking at the patient and checking that there was food in the home and P-1 seemed to be about the same according to these criteria. RN-C stated she did not ever weigh P-1 despite his diagnosis of Failure to Thrive and concerns about his difficulty swallowing because P-1 had no scale. RN-C stated she did not attempt to get a scale for P-1. RN-C stated she checked P-1's skin at the time of the comprehensive assessment, and at his last assessment dated 5/2/2014 he had no open areas. RN-C stated no one told her P-1 had wounds, so no skin check was done at his last skilled nurse visit. RN-C stated she offered P-1 the opportunity to go to a nursing home at some point in the last 2 years, but P-1 wanted to stay in his own home, despite the situation not being ideal. RN-C stated she did not document any conversations about the risk of self-neglect, nor did she inform P-1's physician about self-neglect concerns regarding P-1. RN-C stated she did not know P-1 had lost weight or had wounds and therefore did not report that to P-1's physician. Director of Nursing B (DON-B) was interviewed on 8/15/14 at 12:00 p.m. and stated that a patient with Failure to Thrive as a diagnosis should be having his weight monitored by the home health	G 338		

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G 338	Continued From page 13 agency nursing staff. DON-B stated she became aware of the concern related to P-1's home health care when the hospital called her for his records on approximately 7/1/2014. DON-B called RN-C to ask if a vulnerable adult report was made about P-1's self-neglect. RN-C told DON-B that P-1 was of sound mind and wanted to stay in his own home, so no report about his condition was made. DON-B stated that the agency has interdisciplinary team (IDT) meeting in which staff nurses discuss their patients who are at risk in any area, but RN-C does not participate in the IDT meetings, so administrative staff were not aware of any concern related to P-1's condition. DON-B stated she was RN-C's supervisor, but she had not ever supervised RN-C' during a skilled nurse visit. P-1's primary physician, (MD-E) was interviewed on 8/22/2014 at 10:45 a.m. and stated he had not seen P-1 since June, 2013, one year earlier. At that time there were concerns with decreased nutritional intake and a nutrition consult was ordered. At the time of the nutrition consult in 7/2013 P-1 weighed 105.5 pounds and had difficulty swallowing. MD-E stated he would expect that weights would be monitored on a patient who was at risk for nutrition problems as P-1 was. MD-E stated his physician's office did not get any calls concerning P-1's weight or concerns for self-neglect for the patient at home. MD-E stated that if the office did receive a call regarding weight loss and/or P-1 refusing further intervention, the next step would be to have a discussion with the patient regarding risks of decreased nutrition and refusal of interventions. The policy titled Evaluating the Effectiveness of the Plan of Care/Service Plan dated 8/27/04 and	G 338		

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G 338	Continued From page 14 provided by the agency was reviewed and the following was noted: At Each Encounter 1. The designated employee determines the effectiveness of the plan of care/service plan at each encounter by comparing the patient's current status against the established goals. C) If the patient's current status does not demonstrate expected progress towards established goals, the designated employee: i) Consults with their supervisor and the health care practitioner and/or other responsible party to revise the plan of care/service plan. Under the section titled Follow-up Comprehensive Assessment; Policy: Interim HealthCare employees periodically conduct a comprehensive follow-up assessment of the patient to determine the patient's response to care/services provided, as well as continued appropriateness of such care/services. The policy titled Abuse and Neglect dated 5/14/10 and provided by the agency was reviewed. Under the section titled Definitions and warning signs the following was noted: 7. Self-Neglect: Behaviors of an elderly person that threatens the elder's health or safety. Warning Signs: inadequate or no food, heat or cooling for reasonable daily comfort.	G 338		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
247104	A. Building B. Wing	10/13/2014

Name of Facility	Street Address, City, State, Zip Code
INTERIM HEALTHCARE OF THE TWIN CITIES	2833 NORTH FAIRVIEW AVENUE ROSEVILLE, MN 55113

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix G0134 Reg. # 484.14(c) LSC	Correction Completed 10/13/2014	ID Prefix G0173 Reg. # 484.30(a) LSC	Correction Completed 10/13/2014	ID Prefix G0330 Reg. # 484.55 LSC	Correction Completed 10/13/2014
ID Prefix G0338 Reg. # 484.55(d) LSC	Correction Completed 10/13/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** KL/AK	**Date:** 10/14/2014	**Signature of Surveyor:** 10567	**Date:** 10/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/25/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO