DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report#: H8086004M
Compliance#: H8086003C

Date Concluded: June 21, 2022

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Home Care 4080
W. Broadway
Robbinsdale, MN 55422
Hennepin County

Facility Type: Home Health Agency (HHA)

Evaluator's Name: Lissa Lin, RN
Special Investigator
Revised by: Benjamin Hanson
Revised Date: February 7, 2023

Finding: Not Substantiated

Nature of Visit:

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

Allegation(s):

It is alleged: The alleged perpetrator (AP) neglected the client when she left him alone in his bathtub and went to another home care appointment even though the client experienced altered cognition and was covered in feces when the AP arrived at the client's home. The client was hospitalized with sepsis.

Investigative Findings and Conclusion:

Upon reconsideration, the findings of this report were changed to not substantiated.

~~Neglect was substantiated. The AP was responsible for the neglect.~~ The AP (a licensed

practical nurse) arrived at the client's home to provide wound cares. She found him in bed, covered in feces and confused. While the AP did call the client's physician and the client's family member to relay his condition; she left the client alone in the bathtub and drove to her next appointment despite the client's altered cognition and no assessment of his ability to get out of the bathtub safely on his own. The family member called 911 and the client went to the hospital with possible sepsis.

The investigation included interviews with facility staff members, including administrative staff and nursing staff. The investigator reviewed the client's medical record, incident report and AP personnel records.

The client's medical diagnoses included pyoderma gangrenosum (a rare autoimmune condition that causes painful, rapidly enlarging ulcers), diabetes and chronic pain syndrome. His assessment indicated he had limited endurance and could be up as tolerated.

The client lived alone in his own home and received home health services. The AP provided on- going wound assessments and wound cares three time a week, and biweekly medication management.

One morning, the AP arrived at the client's home to provide wound cares. She found the client in bed covered with feces. There were feces on the sheets and floor. The AP said she woke the client up and told him to shower so she could assess his wounds. The client seemed "groggy" but went into the bathroom to shower. The client was independent with bathing; the AP said he always showered before their wound care appointments.

The AP called the client's dermatologist and requested a prescription for an antibiotic since she was concerned about the fecal matter contaminating his wounds. The dermatologist's office staff asked for a photo of the wounds.

The AP called the client's emergency contact, a family member, and explained the client's condition. The family member told her the client had been ill three days earlier and she would be over in about 10 minutes.

The AP's clinical note indicated the client was confused and could not tell her what happened. He stared at her blankly and it took him several minutes to get out of bed. He had another two episodes of loose stools while in the bathroom. The AP set up the client's medications while he showered. He called out for help once but could not verbalize what he needed. The AP said she did not think the diarrhea was that unusual, because the client had episodes of incontinence.

When the AP went to check on the client again, she found him lying down in the bathtub with the water running. The AP turned off the water and asked him a few times to get up and out of the tub so she could photograph his wounds for the doctor and start cares. The client declined and told the AP to "shut up" and leave, he didn't want wound cares. The AP called the family member back and said the client refused cares and told her to leave. She told the family member she should take the client to the doctor or call 911.

During an interview the AP said she also called her nurse case manager and left a voicemail to call her back about the client and get instruction on what to do. She said she did not call another nurse case manager because she "got the runaround" in the past. The AP said she did not call 911 because the client had declined 911 services with previous pain issues, and he did not look septic even though she did not take any vital signs.

The AP said she decided to go to her next home care appointment. She scheduled her appointments and said she could have stayed with the client until his family came but did not think he was in any danger laying in the tub. The AP said the bathtub water was turned off when she left. She regretted not calling 911.

During an interview, the nurse case manager said the AP's voice message was not urgent. He called her back about 30 minutes after she left the voice message and when he spoke to her, he thought she was still at the client's home. The nurse case manager said the AP should have stayed at the client's home until the family member came.

During an interview a nurse manager said she spoke to the AP about the client's condition and was concerned that she left the client in the bathtub alone. She said the AP had no good answer for why she left the client unattended in a bathtub and at the time did not see the client as a vulnerable adult at that time. There were nurses available at the home health office to call if the AP had questions on what to do.

During an interview, the family member said the client could be defiant at times and refuse cares, but the AP had worked with him for almost two years and should have known he was incoherent, not defiant. The family member said the client did not take baths and could not safely get out of the tub alone. She said she told the AP she was just a few minutes away and did not understand why the AP didn't just wait in another room of the house until she got there. The family member said she found the client lying the bathtub with the cold water tap trickling into the tub and the water near his ears. She said her brother could not explain why he was in the bathtub and did not know the AP had been to the house already. The family member called 911 and sent to the hospital. He was admitted with possible sepsis and dehydration.

The AP's training records included training on vulnerable adults and reporting suspected abuse, neglect, and financial exploitation. The AP's termination form indicated the AP failed to identify the client's limitations, failed to provide care and services necessary to keep the client safe and created a risk for adverse client outcomes including serious injury, serious harm, impairment, or death.

The client was unavailable for an interview.

The AP was no longer employed at the home health agency.

~~In conclusion, neglect was substantiated.~~ **Upon reconsideration, the findings of this report were changed to not 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: Unavailable due to hospitalization.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The AP was no longer employed at home health agency.

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.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Robbinsdale City Attorney
Robbinsdale Police Department
Hennepin County Attorney
Minnesota Board of Nursing