

Office of Health Facility Complaints

Investigative Public Report

Maltreatment Report #: HL02852023M
Compliance #: HL02852024C

Date Concluded: November 2, 2020

Name, Address, and County of Licensee Investigated:

Mission Health Communities LLC
2907 West Bay to Bay Boulevard
Tampa, FL 33629
Hillsborough County

Name, Address, and County of Housing with Services location:

The Residence at North Ridge
5500 Boone Avenue North
New Hope, MN 5528
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:

Maerin Renee, RN
Special Investigator

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 facility neglected to provide assessment and monitoring for the client when she was not feeling well and was unable to contact facility staff for assistance.

Investigative Findings and Conclusion:

Neglect was not substantiated. According to the client's service plan, use of the pendant call light was not a service provided by facility staff. The delay in staff response to the client's call pendant light did not lead to changes in the client's baseline health status.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the client's family member. The investigator reviewed the client's medical record, facility policies, incident reports, vulnerable adult reports, staff schedules, and medication administration documents. The investigator observed staff interacting with clients, including passing medications, performing safety checks, and assisting with personal cares.

The client's diagnoses included dementia, congestive heart failure, gastro-esophageal reflux disease, anxiety, and depression. The client received services from the home care provider that included supervision of dressing, bathing, laundry, shopping, and medication management. Call pendant response services were not specifically addressed in the client's care plan or service plan.

According to facility documentation, several years ago, the client moved into one of the facility's independent living apartments. At that time, the client was alert and walked independently. After a hospitalization, the client's ability to perform activities of daily living declined. The client then transferred to the facility's assisted living.

One night, the client called her family member saying that she was not feeling well and that staff had not responded to her call pendant. The family member called the on-call nurse line and requested a staff member check on the client. About an hour later, the family member called the client, who said no one had yet checked on her. The family member called the nurse line again, but after thirty minutes with no response, he called 911. A police officer arrived at the facility and tried unsuccessfully to enter the building for an hour before a staff member let him in. When the police officer met with the client, who was still not feeling well, he called an ambulance to take her to the hospital. The client stayed at the hospital overnight and returned to the facility the next morning with the assistance of a walker.

During an interview, the facility administrator said there had been a problem with the doors on overnights, and the phone was ringing over but not getting answered by home health aides. The administrator said she hired a licensed practical nurse (LPN) for overnights to monitor the entrance and answer phone calls to remedy the situation. The administrator said that on older call pendants, the reset buttons were not re-setting as they were supposed to, so older pendants are being replaced with new pendants that work correctly.

During an interview, the client's family member said that after a hospitalization, he transferred the client from independent living to assisted living at the facility. One night after the transfer, the client called him because no staff member had responded to the client's call pendant. The client said she was not feeling well, so the family member contacted the on-call nurse. An hour later, the family member called the client, who said no one had yet checked on her. After unsuccessfully trying to call the on-call nurse for thirty minutes, the family member said he called 911 to have someone check on the client. The family member said a police officer arrived at the facility, and it took over an hour for a staff member to let him into the facility. The family member said when the police officer saw the client, the officer called an ambulance to send the client to the emergency room. The emergency room document indicated diagnoses including generalized abdominal pain, elevated liver function tests, fall, and contusion of hip. The family member, however, recalled receiving a call from an emergency room worker and was told they did not find anything wrong and were keeping the client for observation. According to her primary care provider follow-up visit, the client had experienced abdominal pain and dizziness with no recent falls.

The family member said he later learned that the client returned from the hospital with a walker, and was concerned because the client had not needed assistance with walking in the past. A week later, due to COVID-19 and other concerns, the family member took the client home to live with him. He stated after several months, the client's health improved so she returned to an independent living apartment at the facility. The family member said the client enjoys living at the facility, has many friends, and likes the staff, but he found the overall lack of communication alarming. The family member said that he has since talked with the administrator about changes made in the facility in response to the above concerns.

In conclusion, neglect was not substantiated.

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Vulnerable Adult interviewed: No. Given client's cognitive status, the client's family member did not believe an interview would be productive.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:

The facility adjusted its' staffing plan and invested in new equipment to address building access and communication concerns.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H02852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/01/2020
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NAME OF PROVIDER OR SUPPLIER HOME HEALTH AT NORTH RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 5500 BOONE AVENUE NORTH NEW HOPE, MN 55428
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On October 1, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL02852024C/#HL02852023M. At the time of the survey, there were #108 clients receiving services under the comprehensive license.</p> <p>The following correction order is issued/orders are issued for #HL02852024C/#HL02852023M, tag identification 1252.</p>	0 000	<p>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 surveyors' findings is the Time Period for Correction.</p> <p>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 follow-up surveys. 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."</p> <p>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).</p>	
01252 SS=E	<p>144A.4798, Subd. 3 Infection Control Program</p> <p>Subd. 3.Infection control program. A home care provider must establish and maintain an effective</p>	01252		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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01252	<p>Continued From page 1</p> <p>infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19.</p> <p>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 a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>Hand Hygiene</p> <p>The licensee failed to ensure staff engaged in hand hygiene and wore personal protective equipment (PPE) per the Center for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) guidelines.</p> <p>CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated July 15, 2020, indicated that healthcare workers should perform hand hygiene before and after all patient contact.</p>	01252		

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01252	<p>Continued From page 2</p> <p>The recommendations also indicated staff should perform hand hygiene by using alcohol-based hand sanitizer (ABHS) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds.</p> <p>The MDH guidance titled, "Responding to and Monitoring COVID-19 Exposures in Health Care Settings," dated June 8, 2020, indicated on page 2 through 6 that facilities should enforce strict hand hygiene policies throughout the facility.</p> <p>During an observation on September 24, 2020 at 9:55 a.m., unlicensed personnel (ULP)-D entered apartment #21 to deliver medications to a client. ULP-D did not wear gloves, nor did ULP-D perform hand hygiene before or after medication delivery. There was no hand sanitizer observed on the nearest the medication cart.</p> <p>During an observation on September 24, 2020 at 9:58 a.m., ULP-D, after passing medications to a client in apartment #21, did not perform hand hygiene before entering apartment #22 to assess and assist a client who was found on the floor. ULP-D did not perform hand hygiene before or after touching the client.</p> <p>The Hand Washing policy dated November 1, 2019, indicated that hand washing shall be performed between client cares and whenever direct physical contact with a client takes place.</p> <p>The Home Care Orientation policy dated November 1, 2019, indicated infection control techniques that must be followed when administering medications, including hand washing and the use of gloves when appropriate.</p> <p>Employee Records</p>	01252		

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01252	<p>Continued From page 3</p> <p>The MDH document titled, "Covid-19 Toolkit, Information for Long Term Care Facilities," dated August 14, 2020, indicated facilities should conduct COVID-19-specific infection control and prevention (IPC) training for staff.</p> <p>ULP-F's personnel record was reviewed. There was no evidence that ULP-F received any training specific to COVID-19.</p> <p>ULP-G's personnel record was reviewed. There was no evidence that ULP-G received any training specific to COVID-19.</p> <p>ULP-H's personnel record was reviewed. There was no evidence that ULP-H received any training specific to COVID-19.</p> <p>During an interview on September 24, 2020 at 2:20 p.m., Executive Director (ED)-A said she believed COVID-19 training was completed, but the records were not kept in the employee files.</p> <p>The Standard Precautions for Infection Control policy dated November 1, 2019, did not indicate that COVID-19 specific training was a requirement or provided for staff.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01252		