Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL03020003  Date Concluded: March 20, 2019
Date of Visit: January 29, 2019

Name, Address, and County of Licensee Investigated:
Saint Therese Residence
8008 Bass Lake Road
New Hope, MN 55428
Hennepin County

Facility Type: Home Care Provider  Investigator’s Name: Casey DeVries, RN

Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An unannounced visit was conducted to investigate 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 that a client was neglected by facility staff when they failed to assist with oxygen, resulting in cyanosis to fingertips and nails. Additionally, the client had not received any scheduled services and was found saturated in urine.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment due to an inadequate contingency plan during a staffing shortage, which resulted in a failure to supply the client with oxygen administration, medication reminder, toileting and incontinence care, and a meal. Additionally, there was evidence to suggest that the client also did not receive services as scheduled in the evening or overnight hours prior to the incident.

During the investigation, the investigator conducted interviews with seven facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also conducted interviews with two hospice staff members and a family member. The

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investigator made observations of the day-to-day operation of the facility, including staff’s assignment system, methods for communication, meal service, facility cleanliness, and staff’s interactions with clients. Additionally, the investigation included review of the facility’s policies and procedures, grievances, documentation of services provided, staff scheduling, staff meeting minutes, marketing materials, and client medical records.

The client received services from the comprehensive home care provider for activities of daily living including dressing, grooming, bathroom assistance, medication reminders, oxygen administration, escorts to meals and activities, reassurance checks, and as needed dressing changes to a leg wound, which was primarily managed by a third party hospice agency. The client utilized a wheelchair and was dependent on staff for all transfers and mobility. The client’s medical record indicated that, due to a cognitive medical diagnosis, the client was confused at baseline, and was only oriented to herself. The record indicated that, during a recent assessment, the client’s oxygen level while on supplemental oxygen at four liters per minute was 96%.

Documentation in the client’s medical record revealed that facility staff failed to document the delivery of any scheduled services for the client in the evening hours prior to the incident after 6:00 p.m., or for any services scheduled during the overnight hours prior to the incident.

On the day of the incident, the client’s hospice nurse arrived to the facility for a routine visit at approximately 11:00 a.m. The nurse found the client lying in bed, calling out for help, saturated with urine, and connected to an empty portable oxygen tank. The nurse documented that the client’s lips and fingernails had blue discoloration and that the client’s oxygen levels were below normal at 82%. After immediately applying oxygen to the client, the hospice nurse reported the client’s condition to facility management and inquired about the client’s care that morning.

During an interview, the hospice nurse stated that the client was breathing heavily and appeared uncomfortable as she was lying in urine. The hospice nurse stated that, although the client wore a pendant bracelet, the client likely would not have been able to recognize the need to call for help, not only due to her cognitive diagnoses, but also due to the low oxygen level, which would have contributed to increased confusion. The nurse stated the client was dependent on the facility staff anticipating her needs.

Upon investigation, facility management discovered that, when a caregiver who was scheduled to work in the facility’s memory care area that morning called in to work, a float staff member who was responsible for the client, moved to the memory care area to help cover. With two-way radios, the remaining staff verbally divided the group of clients that the float staff member had been responsible for; however, the staff mistakenly failed to include this client. As a result, no one was responsible for the client’s scheduled services.

During interviews, staff members who worked the morning of the incident stated that, at the time, it was routine to discuss amongst themselves who was going to take which clients
following any call in, either by a face-to-face meeting or announcement of client room numbers over a two-way radio to each other. Staff members stated that there was no alert to inform them that a client’s care was omitted, unless they each manually logged into the assignment of the staff who called in. The staff members stated they did not learn that the client had been missed until they were called to the nurse’s office for questioning late that morning.

During an interview, a consultant nurse who was filling in as the facility’s registered nurse (RN) at the time of the incident stated that the staff did not follow a protocol for a call in, although she was unable to recall specifically what that protocol was. The RN stated that staff would have had to log in to the assignment of a caregiver using an electronic device in order to see the entire client list assigned to that caregiver; however, that was not done, and thus the client was missed. The RN stated she was uncertain why the client would have been on the portable oxygen tank while in bed, but suggested that some of the staff might have been nervous to use the client’s larger oxygen tank due to a previous issue, despite resolution to the problem and re-education. The RN stated that she did not recall investigating if the client had received cares after the last documentation, which was at 5:29 p.m. the day before the incident, and could not say for sure that the client had received services as scheduled.

During an interview, the client’s family member stated the client was dependent on staff to assist with oxygen administration, toileting, and mobility, and that cognitively, the client might not have been able to recognize that she needed help. The family member stated that, after the occurrence, family members had a meeting with management to find out what happened and were told that corrective measures were being implemented for future staff call ins. The family member stated that s/he requested the corrective action in writing, but never received it.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
   (1) reasonable and necessary to obtain or maintain the vulnerable adult’s physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
   (2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult’s health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. The client was deceased at the time of the investigation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility implemented a new system for when staff call in, which included posting specific re-assignment instructions for each caregiver group so there would be no questions about which staff members were responsible for which clients.

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: http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm, 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.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
New Hope City Attorney
New Hope Police Department
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>Initial Comments</td>
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<td>Minnesota Department of Health is documenting 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 &quot;ID Prefix Tag.&quot; The state Statute number and the corresponding text of the state Statute out of compliance is listed in the &quot;Summary Statement of Deficiencies&quot; column. This column also includes the findings that are in violation of the state requirement after the statement, &quot;This Minnesota requirement is not met as evidenced by.&quot; Following the surveyors' findings is the Time Period for Correction. Please disregard the heading of the fourth column which states &quot;Provider's Plan of Correction.&quot; 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. However, home care providers are required to document any action taken to comply with these correction orders, per Minn. Stat. 144A.474, Subd. 8(c). 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).</td>
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<td>0 325 SS=G</td>
<td>144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal</td>
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: __________________________
TITLE: __________________________

[X8] DATE: __________________________
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abuse, neglect, financial exploitation, and all forms
of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

This MN Requirement is not met as evidenced by:
Based on interview and document review, the licensee failed to ensure that 1 of 1 client (C1) was free from maltreatment when the licensee did not ensure the client received scheduled services that were reasonable and necessary to maintain C1’s physical or mental health or safety. The licensee did not ensure that appropriate staff reported to C1’s home for duty, and did not have an appropriate contingency plan during a staffing shortage, which resulted in C1 missing her scheduled medications, being without oxygen for an undetermined amount of time, having decreased oxygen saturation levels, being found saturated in urine, and missing breakfast.

This practice resulted in a level three violation (a violation that harmed a client’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 clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

C1 received comprehensive home care services for diagnoses that included atrial fibrillation, dementia, and chronic respiratory failure with hypoxia. C1 received assistance with dressing,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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**ST THERESE RESIDENCE NURSING**

8008 BASS LAKE ROAD
NEW HOPE, MN 55428

**SUMMARY STATEMENT OF DEFICIENCIES**

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**PROVIDER'S PLAN OF CORRECTION**

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Grooming, bathroom assistance, medication reminders, oxygen administration, escorts via wheelchair to all meals and activities, nighttime reassurance checks at 12:00 a.m. and 3:00 a.m., and as needed dressing changes to a leg wound, which was primarily managed by a third party hospice agency. C1 was dependent on staff for transfer assistance in/out of bed, on/off the toilet, and in/out of her wheelchair.

C1's physician order dated, June 15, 2018 indicated an oxygen order for 4 liters/minute, continuous, for comfort and shortness of breath.

C1's nursing assessment dated, July 9, 2018 indicated that C1 was wheelchair bound and was dependent on staff for assistance with activities of daily living such as transfers, toileting, incontinence care, oxygen administration, and reminders to take medications following a set up done by hospice or C1's family. The assessment indicated that C1's oxygen saturation level with use of oxygen at 4 liters per minute at the time of the assessment was 96%. The assessment did not address C1's ability to utilize her call pendant, however, indicated that C1 had severe cognitive impairment and was oriented only to herself.

C1's hospice progress note dated, August 14, 2018 and signed by registered nurse (RN)-B at 11:30 a.m., indicated RN-B found C1 in bed in her pajamas, soaked in urine. The note indicated C1's left leg was weeping and that C1 had blue discoloration around her lips and fingernails. C1's oxygen tubing was connected to an empty portable oxygen tank and C1's oxygen saturation level was 82%. C1 was calling out for help.

C1's service check off document dated August
**ST THERESE RESIDENCE NURSING**

**8008 BASS LAKE ROAD**

**NEW HOPE, MN 55428**

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2018 lacked evidence of services delivered by the staff to C1 after what appeared to read as 5:29 p.m., on August 13, 2018. The service check off lacked documentation for the following scheduled services:  
8/13/2018- 8:15 p.m., Oxygen administration  
8/13/2018- 8:15 p.m., Dressing assistance  
8/13/2018- 8:15 p.m., Medication reminder  
8/13/2018- 9:30 p.m., Home Health Aide visit to assist to bed and ensure oxygen is dialed to 4  
8/13/2018- 11:00 p.m., Reassurance check and oxygen check  
8/14/2018- 3:00 a.m., Reassurance check and oxygen check  
8/14/2018- 6:15 a.m., Bathroom assistance  
8/14/2018- 8:00 a.m., Oxygen administration  
8/14/2018- 8:00 a.m., Dressing assistance  
8/14/2018- 8:00 a.m., Medication reminder  
8/14/2018- 8:30 a.m., Personal Hygiene  
8/14/2018- 9:00 a.m., Escort to meals with portable oxygen  
8/14/2018- 9:45 a.m., Bathroom assistance  
8/14/2018- 9:45 a.m., Oxygen administration  
8/14/2018- 10:45 a.m., Bathroom assistance  
8/14/2018- 10:45 a.m., Escort to church  

A document titled, "Saint Therese Internal Investigation Form," dated August 14, 2018 and signed by RN-C, revealed a summary indicating that C1 did not receive the contracted care on the morning of August 14, 2018 due to a mistake when assigning clients to staff after a home health aide called-in earlier that morning. The mistake resulted in the remaining staff forgetting to assign C1 to another staff member. The investigation included notes of interviews conducted with a hospice nurse and five home health aides. The investigation lacked inquiry into the last time any staff had contact with C1, or of
Continued From page 4

interviews with staff from the preceding evening or overnight shift staff who were responsible for the care of C1.

During an interview on March 18, 2019 at 4:06 p.m., hospice registered nurse (RN)-B stated on August 14, 2018 she visited C1 and found her lying in bed with no supplemental oxygen flowing, and with dark blue lips and fingernails. RN-B stated that C1 was breathing heavily and appeared uncomfortable as she was lying in urine. RN-B stated that she immediately applied oxygen to C1 to bring her oxygen saturation levels back to normal, and then notified facility management. RN-B stated that although C1 wore a pendant call bracelet, C1 would not have been able to recognize the need for help, not only due to her dementia, but also due to her low blood oxygen level. RN-B stated that C1 was dependent on staff anticipating her needs.

During an interview on January 29, 2019 at 11:39 a.m., home health aide (HHA)-D stated that at the time of C1's incident, staff were new to using iPads for documentation. HHA-D stated there was nothing on the device that alerted staff if a client on another staff's schedule was missed unless that staff manually pulled up the assignment to look at it. HHA-D stated the practice at the time of C1's incident was that if a staff called in, the remaining staff would just discuss and decide amongst themselves which clients they were going to pick up off that schedule for the day. HHA-D stated that on the day of C1’s incident, the staff chose clients over the two-way radios, announcing which room numbers they would go to, based on the discussion about which clients had already received morning cares. HHA-D stated it was not...
Continued From page 5

until staff were called down to the office that they learned C1 had been missed.

During an interview on January 29, 2019 at 2:11 p.m., home health aide (HHA)-F stated that s/he was a float staff the morning of August 14, 2018. HHA-F stated s/he had already taken care of two clients, and was headed to C1’s apartment when a call came informing him/her to go cover the memory care area due to a staff shortage. HHA-F stated s/he informed the other staff of which clients s/he had already provided cares to and then went to the memory care area. HHA-F stated that when staff call in to work, the remaining staff share the schedule by picking which clients to assist. HHA-F stated there was no formula to it.

During an interview on January 29, 2019 at 2:49 p.m., office assistant (OA)-G stated at the time of C1’s incident, when a staff member would call in to work, the practice was that the remaining staff would radio each other to discuss amongst themselves how to spit up the remaining clients.

During an interview on March 19, 2019 at 10:26 a.m., registered nurse (RN)-C stated that she conducted the investigation after C1’s incident. RN-C stated that she found the staff did not follow a protocol for a call in, although she was unable to recall specifically what the protocol at that time was. RN-C stated that staff would have had to specifically log in to the assignment of the caregiver that called in, in order to see the clients on that care schedule, however that day, staff had only discussed the schedule amongst themselves, which contributed to C1 getting missed. The RN stated that even if the staff did log into the assignment list, however, if staff
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waited until the end of the shift to document on
the clients they provided care to, they may have
just assumed the client received care from
another staff who had not yet documented. RN-C
stated she could not recall if she looked into the
last time C1 had any contact with staff prior to the
hospice nurse finding her on the morning of
August 14, 2018. RN-C stated that she could not
say for sure if C1 received any care after the last
documentation at 5:29 p.m., on August 13, 2018,
and that she would have documented that
information in her investigation. RN-C stated she
did not know why C1 would have been on the
portable oxygen tank while in her bed. RN-C
suggested that due to a previous issue with the
larger tank leaking and hissing, which had been
resolved, some of the staff were still nervous
about using it despite resolution and
re-education. RN-C stated after the occurrence,
new expectations were implemented for when
staff called in, which included posting specific
re-assignment instructions for each group so
there would be no questions about which staff
were responsible for which clients.

During an interview on March 18, 2019 at 9:33
a.m., family member (FM)-H stated that
historically, a lack of attention at the facility was a
problem, for which the family had multiple
conversations with facility management. FM-H
stated that C1 was dependent on staff to assist
with her oxygen administration, toileting, and
mobility and that cognitively, C1 might not have
been able to recognize that she needed help.
FM-H stated after the occurrence on August 14,
2018, family members had a meeting with
management staff to find out what happened and
were told that corrective measures were being
implemented for future staff call-ins. FM-H stated
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that the family requested the corrective action in writing, however, it was never received. FM-H stated that communication with the facility was a problem, especially due to turnover of a main contact person, and although there were some attentive staff members during the week, on the weekend, staffing at the facility was horrendous.

A facility policy titled, "Vulnerable Adult, Reporting of Maltreatment of", dated August 1, 2017 identified neglect as the failure or omission by a caretaker to supply a VA (vulnerable adult) with care or services, including, but not limited to: food, clothing, shelter, health care or supervision which is reasonable and necessary to obtain or maintain the VA’s physical or mental health or safety, considering the physical and mental capacity or dysfunction of the VA and which is not an accident or therapeutic conduct, and could have been reasonable prevented.

TIME PERIOD FOR CORRECTION: Seven days