Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL03383035M
Compliance #: HL03383036C

Date Concluded: December 9, 2019

Name, Address, and County of Housing with Services location:
Augustana Home Health Care Services
901 4th Ave North
Minneapolis, MN 55405
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Allegation(s):
It is alleged: the facility neglected the client when she did not have her call pendant within reach and was unable to call for help and fell out of her bed and hit her head.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility neglected a client when her call pendant was removed from her neck and placed out of reach. As a result, the client was unable to call for help when she needed to use the bathroom and fell out of bed, hit her head, and laid on the floor for an undetermined amount of time.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed members of the client's support system. The client's medical record was reviewed. The investigator observed staff members assisting clients with mobility and hygiene cares. The investigation included review of facility policies and procedures and incident reports.

The client's diagnoses included Huntington's disease, impaired mobility, osteoporosis, cognitive deficit, osteoarthritis, anxiety disorder, and movement disorder.

A review of an incident report indicated the client was found on the floor close to the bathroom and appeared as if she was trying to make her way to the bathroom. The client does not speak English and was unable to communicate to the staff what happened. It was documented that the client had a knot on her left eyebrow and was transported to the hospital for observation.

A request was made for the call pendant report for the day before and the day the client fell. The last pendant call was made by the client the day before on the evening shift. The investigator was informed there were no pendant calls made by the client on the day of the incident. This was incongruent with call pendant reports from other dates that showed the client at times, would call approximately every five minutes. The call pendant log indicated a pattern where the client would press the pendant repeatedly, followed by periods of no use.

During an interview, a staff member stated she was not sure if the client was wearing her pendant when she came into work. When a family member complained that the client did not have her pendant, the staff member returned, stating she found the pendant on top of the client's dinner plate. The staff member stated she was aware there was an issue with the client not having her call pendant, but she did not know who would have taken the pendant, if the pendant was taken.

During an interview, a nurse stated that when the client fell, she did not have her call pendant around her neck and it was placed at the client's bedside. The nurse stated the client was found on the floor during the scheduled two-hour safety check.

During an interview, another nurse stated the client is constantly ringing the call pendant and the staff cannot understand what the client wants because she does not speak English. The nurse stated that she was aware of the issues with the pendant being removed, and staff had been retrained on the importance of the clients having a call pendant.

During an interview, a family member stated she had found the client without her call pendant, on numerous occasions before and after the incident. The family member stated the client informed her that staff members take her pendant but she did not know why. The family member stated she was informed by administration that the staff member responsible was no longer employed by the facility. The family member stated the pendant was missing again after this employee was gone. The family member stated she informed a staff member the pendant was missing and the staff member stated she noticed it was missing when she arrived to work. When the staff member returned with the pendant, the client told the family member that staff member was the person that took the pendant from her. The staff member denied this.

In conclusion, neglect was substantiated. There was a preponderance of evidence that there was an absence of a way for the client to contact staff and communicate her needs, which was

necessary to the client's safety. Whether this was due to staff intentionally taking away the pendant as reported, or failure to perform the service of ensuring the client had the pendent, this constitutes neglect.

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, client did not speak English.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility stated staff members were re-educated on the importance of the client having a call pendant and the importance of answering the call pendant in a timely manner, although no documentation of that re-education was provided.

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.

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

Cc: The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Hennepin County Sheriff's Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H03383	A. BUILDING: _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HOME HEALTH CARE SERVICES	901 4TH AVENUE NORTH MINNEAPOLIS, MN 55405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER 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. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On November 1, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL03383036C/#HL03383035M, #HL03383038C, #HL03383037M, #HL03383040C, #HL03383039M. At the time of the survey, there were 50 clients receiving services under the comprehensive license. The following correction order is issued for #HL03383036C/#HL03383035M, tag identification 0325.	0 000	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. 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." 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).	
0 325 SS=G	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 325		

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0 325	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal 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 one of six clients (C1) reviewed were free from maltreatment (neglect) when C1 did not have her call pendant within reach and was unable to call for help, fell out of bed, and hit her head. Client was transported to hospital for observation. Interviews, as well as the patterns of call light use, indicated staff intentionally took away C1's call pendant because she used it frequently, and the facility did not have a system for understanding C1's requests. 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's medical record was reviewed. C1's diagnosis included Huntington's disease, impaired mobility, osteoporosis, cognitive deficit, osteoarthritis, anxiety disorder, and movement	0 325		

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0 325	Continued From page 2 disorder. C1's plan of care dated November 1, 2019, indicated C1 received services from the comprehensive home care provider for medication management, bathing and grooming assistance, safety checks, transfer and toileting assistance, and feeding assistance. A review of an incident report dated July 6, 2019 at 1:08 a.m., indicated C1 was found on the floor close to the bathroom with her pants down to her knees and BM on her body and on the floor. C1 does not speak English and was unable to communicate to the staff what had happened. It was documented that the client had a knot on her left eyebrow and was transported to the hospital for observation. A review of C1's post fall huddle worksheet dated July 20, 2019, indicated C1's call pendant was not on her when she fell. A list of reasons for the client's fall included the following; the resident wanted to use the bathroom, she did not use her pendant, she cannot go to the bathroom alone, and she uses the pendant too much. A request was made for the call pendant report for July 6, and 7 2019. On July 6, 2019, the last pendant call was made at 9:08 p.m. The investigator was informed there were no pendant calls made by the client on July 7, 2019, the day of the incident. This was incongruent with call pendant reports from other dates that showed the client at times, would call approximately every five minutes. During an interview on November 1, 2019, at 2:51 p.m., nurse-D stated that when C1 fell, she did not have her call pendant around her neck and it was placed at C1's bedside. Nurse-D stated C1 was found on the floor during the scheduled two	0 325		

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0 325	Continued From page 3 hour safety check. During an interview on November 4, 2019, at 10:59 a.m., unlicensed personnel (ULP-F) stated she was not sure if C1 was wearing her call pendant when she came into work on November 2, 2019. When a family member complained that C1 did not have her pendant, the ULP-F returned and stated she found the pendant on top of C1's dinner plate. ULP-F stated that she was aware there was an issue with C1 not having her call pendant, however, she did not take C1's pendant, and she did not know who would have taken the pendant, if the pendant was taken. During an interview on November 4, 2019, at 3:24 p.m., a family member stated she had found C1 on numerous occasions without her call pendant. The family member stated C1 informed her that staff members take her pendant but she did not know why. The family member stated she was informed by administration that the staff member responsible was no longer employed by the facility, however they did not reveal to her who that employee was. The family member stated the pendant was missing again on November 2, 2019. The family member stated she informed ULP-F that the pendant was missing and ULP-F stated she noticed it was missing when she came into work. When ULP-F returned with the call pendant, C1 identified ULP-F as the staff that took pendant from her. During an interview on November 21, 2019, at 10:37 a.m., nurse-I stated C1 is constantly ringing the call pendant and the staff cannot understand what C1 wants because she does not speak English. Nurse-I stated that she was aware of the issues with the pendant being removed, and staff had been retrained on the importance of the	0 325		

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0 325	Continued From page 4 clients having a call pendant. A policy titled Fall Prevention and Reduction dated August 2017, indicated the following: In the event of a fall the interdisciplinary team will review the care plan and the following will be considered; review of care approach, current toileting schedule, and any other factors that have impacted the resident's risk for falling, and a post fall huddle will be conducted to assist in identifying the root cause. A policy titled Vulnerable Adult Policy dated November 11, 2017, indicated the following: Residents admitted to or participating in Augustana Care facilities, entities, and programs have the right to be free from maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		