

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL03383035M Date Concluded: December 9, 2019

Compliance #: HL03383036C

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

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER AUGUSTANA HOME HEALTH CARE SERVICES (X4) ID PREFIX STREET ADDRESS, CITY, STATE, ZIP CODE MINNEAPOLIS, MN 55405 Description of the content		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HOME HEALTH CARE SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 901 4TH AVENUE NORTH MINNEAPOLIS, MN 55405 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL TAG 10 000 Initial Comments 10 000 Initial Comments 11 0 000 Initial Comments 12 0 000 Initial Comments 13 0 000 Initial Comments 14 0 000 Initial Comments 15 0 000 Initial Comments 16 0 000 Initial Comments 17 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				7. 50.25.110	·	
AUGUSTANA HOME HEALTH CARE SERVICES One			H03383	B. WING		11/01/2019
XAJID SUMMARY STATEMENT OF DETICIENCIES DEPRETER TAG SUMMARY STATEMENT OF DETICIENCY PRETER TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 1	NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY,	STATE, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY PREFIX TAG	AUGUST	ANA HOME HEALTH	CARE SERVICES 901 4TH	AVENUE NO	RTH	
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1 0 000 Initial Comments 1 0 000 Initial Comments 1 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	A000017		MINNEA	POLIS, MN (55405	
******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 Complaint #HL03383036C/#HL03383035M, #HL03383036C/#HL03383037M, #HL03383038C, #HL03383037M, #HL03383036C/#HL03383037M, #HL03383036C/#HL03383035M, #HL03383036C/#HL03383035M, tag identification 0325. The following correction order is issued for #HL03383036C/#HL03383035M, tag identification 0325. The letter in the left column is used for the fourth column, in the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute out of complaine at papears 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 Perifix Tag." 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 sevidenced 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 required to submit a plan of correction for approval; please disregard the heading of the fourth	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota 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 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, #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. documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Statue Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 statute out of compliance are listed in the "Summary Statement of Deficiencies" fondings that are in violation of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" findings that are in violation of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" findings that are in violation of the state statute out of compliance. Fer Minnesota Statuse tenumber and the corresponding text of the state statuse out of compliant are in violation of the state statuse out of compliant are in violation of the state statuse out of compliant are in violation of the s	0 000	Initial Comments		0 000		
and level issued pursuant to Minn. Stat. §		HOME CARE PROCORRECTION OR In accordance with 144A.43 to 144A.45 of Health issued a casurvey. Determination of wherequires compliance provided at the state When a Minnesota items, failure to combe considered lack INITIAL COMMENT On November 1, 20 Department of Heacomplaint #HL0338 3038C, #H#HL03383038C, #H#HL03383040C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C, #H#HL03383038C/#H##HL03383038C/#H##HL03383038C/#H##HL03383038C/####HL03383038C/####################################	VIDER LICENSING DER Minnesota Statutes, section 32, the Minnesota Department correction order(s) pursuant to the ther a violation is corrected with all requirements ute number indicated below. Statute contains several inply with any of the items will of compliance. TS: 19, the Minnesota Ith initiated an investigation of 3036C/#HL03383035M, HL03383037M, HL03383039M. At the time of ere 50 clients receiving comprehensive license.		documents the State Licensing Corders using federal software. Tarnumbers have been assigned to Minnesota State Statutes for Homeroviders. The assigned tag numbers in the far left column ention Prefix Tag." The state statute numbers to compliance are listed in the "Summary Statement of Deficient column. This column also include findings that are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the survindings is the Time Period for Core Minnesota Statute § 144A.478(c), the home care provider must document any action taken to conthe correction order. A copy of the provider's records documenting the actions may be requested for following the surveys. The home care provider required to submit a plan of corrections may be requested for following the surveys. The home care provider required to submit a plan of corrections may be requested for following the surveys. The home care provider required to submit a plan of corrections approval; please disregard the heather fourth column, which states "Following purposes and reflects the tracking purposes and reflects the	ne Care ber tled "ID nber and e statute cies" s the state This as eyors' rrection. 4, Subd. t nply with cose ow-up is not ction for ading of Provider's ed for e scope
0 325 SS=G Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or		Subdivision 1.State	ment of rights. (a) A client who)	•	. Olat. 3

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
				, a boilbinto.			2
		H03383		B. WING		11/0	1/2019
NAME OF	PROVIDER OR SUPPLIER			,	STATE, ZIP CODE		
AUGUS	TANA HOME HEALTH	CARE SERVICES	_	VENUE NOI OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FORMATED SCIDENTIFYING INFORMATED SCIDENTIFYING INFORMATED SCIENTIFY IN THE PROPERTY IN THE PROP	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
0 325	Continued From pa	ige 1		0 325			
	chapter 144G has to (14) be free from plants neglect, financial extends maltreatment cover	facility licensed under these rights: hysical and verbal abused xploitation, and all form red under the Vulnera Maltreatment of Minor	use, ms of ble				
	by: Based on interview licensee failed to en (C1) reviewed were (neglect) when C1 within reach and was out of bed, and hit has transported to hosp Interviews, as well a use, indicated staff	•	v, the clients ent endant elp, fell light ay C1's				
	violation that harmed not including serious or a violation that has serious injury, impairs and issued at an isolate limited number of collimited number of serious injury.	ed in a level three violed a client's health or so injury, impairment, as the potential to lead irment, or death), and elients are affected or elients are involved or the red only occasionally)	safety, or death, d to d was r a one or a e				
	The findings include	e:					
	diagnosis included impaired mobility, o	d was reviewed. C1's Huntington's disease, steoporosis, cognitive ety disorder, and move	e deficit,				

Minnesota Department of Health

STATE FORM MGNN11 If continuation sheet 2 of 5

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 4TH AVENUE NORTH MINNEAPOLIS, NN 55405		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	` ′	E SURVEY PLETED
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 clients fall included the foliowing; 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 calls was made at 908 p.m. The investigator was informed there were no pendant calls made by the client on there cannot go to the client. This was incongruent with call pendant reports of the lincident. This was incongruent with call pendant reports for the client. This was incongruent with call pendant reports for other the client. This was incongruent with call pendant reports for other the client. This was incongruent with call pendant treport for other that is showed the client at times, would call approximately every five			H03383	B. WING		I	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 1.09 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 calls 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			CARE SERVICES 901 4TH	AVENUE NOR	TH		
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
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	0 325	disorder. C1's plan 2019, indicated C1 comprehensive hor medication manage assistance, safety of assistance, and feet. A review of an incide at 1:08 a.m., indicated close to the bathrook knees and BM on his does not speak Engage communicate to the was documented the left eyebrow and was for observation. A review of C1's pour July 20, 2019, indicated to use the beginner of the included wanted to use the beginner of the incident. This pendant call was minvestigator was inficially made by the confident at times, wou minutes. During an interview p.m., nurse-D state.	of care dated November 1, received services from the me care provider for ement, bathing and grooming checks, transfer and toileting eding assistance. Lent report dated July 6, 2019 ted C1 was found on the floor om with her pants down to her per body and on the floor. C1 glish and was unable to estaff what had happened. It hat the client had a knot on her has transported to the hospital st fall huddle worksheet dated ated C1's call pendant was not li. A list of reasons for the lither than the following; the resident pathroom, she did not use her of go to the bathroom alone, endant too much. Le for the call pendant report 19. On July 6, 2019, the last hade at 9:08 p.m. The formed there were no pendant she was incongruent with call mother dates that showed the lid call approximately every five to November 1, 2019, at 2:51 did that when C1 fell, she did				

Minnesota Department of Health

STATE FORM MGNN11 If continuation sheet 3 of 5

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		, ,	E CONSTRUCTION	(X3) DATE COME	E SURVEY PLETED
		H03383		B. WING			C 01/2019
	PROVIDER OR SUPPLIER	CARE SERVICES	901 4TH A	ORESS, CITY, S VENUE NOF OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
0 325	10:59 a.m., unlicentifications and stated she four dinner plate. ULP-Fithere was an issue pendant, however, and she did not known pendant, if the pendant, if the pendant, if the pendant and staff members take known why. The family member staff members take known why. The family members take what employee was the pendant was members took pendant from the call pendant and what C1 wants because the call pendant and wants the call pendant and wants the call pendant and wants the call p	con November 4, 2019 sed personnel (ULP-F C1 was wearing her came into work on Nomily member complain pendant, the ULP-F and the pendant on top stated that she was a with C1 not having he she did not take C1's ow who would have taken. I on November 4, 2019 ber stated She had for stated C1 informed he her pendant but she sions without her call persons without her call persons without her stated She stration that the staff residence on November stated she stration that the staff residence on November stated she informed by did not reveal to her stated she informed she informed she informed with the staff residence on November stated she informed with the staff residence of the staff of	stated call vember ned that returned of C1's aware r call pendant, ken the stated mber 2, ormed ULP-F he came call that 19, at ly ringing erstand eak	0 325			
	-	dant being removed, a on the importance of					

Minnesota Department of Health

STATE FORM MGNN11 If continuation sheet 4 of 5

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	H03383	B. WING			C 01/2019
NAME OF PROVIDER OR SUPE	LTH CARE SERVICES 901 4TH	DORESS, CITY, S AVENUE NOF POLIS, MN 5		•	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
dated August 2 event of a fall the care plan a review of care schedule, and impacted the r fall huddle will identifying the A policy titled Y November 11, Residents adn Augustana Ca have the right	a call pendant. all Prevention and Reduction 017, indicated the following: In the ne interdisciplinary team will review nd the following will be considered; approach, current toileting any other factors that have esident's risk for falling, and a post oe conducted to assist in		DEI IGIENC		

Minnesota Department of Health STATE FORM