Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL033833321M
Compliance #: HL033833463C

Date Concluded: September 11, 2024

Name, Address, and County of Licensee Investigated:
Augustana Home Health
901 4th Ave N
Minneapolis MN 55405
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Maggie Regnier
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The licensee neglected a client when the facility did not set up oxygen for the client.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true there was a delay in getting the client's home oxygen setup, the delay was caused by miscommunication between multiple agencies and intermittent hospitalization(s). The home care agency helped get the oxygen setup for the client.

The investigator conducted interviews with licensee staff members, including administrative staff, and nursing staff. The investigator contacted the care coordinator for the client. The investigation included review of licensee records, client residents, medical records and policies and procedures.

The client received comprehensive home care services in their apartment. The client's diagnoses included chronic obstructive pulmonary disease, and epilepsy. The client's service plan included assistance with bathing, dressing and grooming and medication management. The client's assessment indicated the resident used a wheelchair but could transfer himself without assistance.

One month a concern arose that the client required home oxygen, but the home care provided did not set it up in a timely manner.

On the 9th day of the month, a summary from the medical provider indicated the client had low oxygen saturations rates with activity. The provider ordered oxygen therapy for the client. This document also notes the client slid of his bed while the provider was present.

On the 10th day of the month, the progress indicated the licensee acknowledged the new oxygen orders. This document also stated the next day the resident was sent to the hospital for low oxygen rates.

On the 11th day of the month, the progress notes indicated the staff at the hospital planned to coordinate the oxygen set up for the client in his apartment when he returned.

On the 12th day of the month, the progress notes indicated the client was returned home without oxygen. The same document indicated the client was sent back to the hospital for low oxygen saturation rates because oxygen had not been delivered at this time.

On the 14th day of the month, the progress notes indicated the client returned to his apartment.

On the 15th day of the month, the progress notes indicated the resident requested to go to the emergency department for pain medication. The same note indicated the clients home oxygen had not been delivered so the nurse reached out to the hospital to address the concern.

On the 16th day of the month, the progress notes indicated the client returned to his apartment with new pain medication orders however once again without oxygen. He same document indicated the client's oxygen levels dropped and the resident returned to the hospital.

On the 17th day of the month, the progress notes indicated the oxygen company had attempted to call the client but was unable to reach him but could deliver and set up the oxygen that day. The nurse agreed to assist with this set up and the client returned home with oxygen that day.

During an interview, the director stated that the physician's office that orders the oxygen usually sets up the oxygen delivery for the client. The director stated that did not happen in this case.

During an interview, the nurse stated that she does not set up oxygen delivery for clients, and also stated that is usually done by the clients care coordinator. The nurse stated she worked with the hospital to get the oxygen set up but that the resident was not home when the oxygen delivery company attempted to set up the oxygen in the client's home. The nurse stated there was a communication issue, but she assessed and cared for the resident the best she could by sending him back to the hospital until the oxygen delivery could take place.

In conclusion, the Minnesota Department of Health determined 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: attempted.
Family/Responsible Party interviewed: no, resident is responsible for self: no family listed.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The licensee monitored the client and acted appropriately when needed while trying to get oxygen delivered.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 08/15/2024

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 On August 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL033833463C/#HL033833321M. No correction orders are issued.	0 000		