Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL033836584M
Compliance #: HL033832347C

Date Concluded: February 27, 2024

Name, Address, and County of Licensee Investigated:
Augustana Home Health Care Service
901 4th Avenue North
Minneapolis MN, 55405
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Kris Detsch, RN
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 facility neglected a client when they withheld food and fluids. As a result, the client required hospitalization for weight loss and malnutrition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the client received hospital care for nutritional loss, the client had multiple diagnoses contributing to her health decline. The facility provided meals to the client, and she fed herself.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the medical provider. The investigation included review of client records, and employee files. Also, the investigator toured the facility and observed staff provide meal service and administer medications.

The client received comprehensive home care services in their home. The client's diagnoses included ataxia (balance loss), arthritis, breast cancer, and depression. The client's service plan included assistance with toileting, bathing, grooming, dressing, meals, and medications. The client had a chronic wound on her skin and required staff to remind her to stand and reposition her body. The client's nursing assessment indicated she was alert and orientated but had mild forgetfulness. The client was able to communicate her needs.

The client's records indicated one month prior to her hospitalization, endocrinology (specialty dealing with the hormone system) evaluated her and found she had an enlarged thyroid gland (produces hormones which regulate the body's metabolic rate). The client required more testing of her thyroid gland which was in process at the time of her hospitalization. The client received frequent blood draws because she took blood thinning medication to prevent further blood clots in her lungs. Also, the client started a course of antibiotic medication three days prior to her hospitalization because she continued to have frequent urination.

Documentation from the client's medical provider indicated she assessed the client, at the facility, six days prior to her hospitalization. The client had increased urine frequency but no other symptoms of an infection.

The investigator requested hospital records, but the hospital failed to respond to the request.

The medical provider requested indicated the client's lab work showed there was no infection, therefore, the medical provider made other medication changes to reduce the client's urine frequency. The medical provider's visit notes indicated the client denied difficulty swallowing, increased fatigue, weight gain or loss, but was at risk of further decline in her health due to breast cancer, ataxia, and history of pulmonary embolism.

The facility weight log indicated the client's lost approximately forty-one pounds over three years, however it was unclear how the facility staff weighted her (with or without her wheelchair). Documentation of the client's weights varied greatly so it was difficult to determine the extent of the weight loss she sustained.

The client's readmission service agreement indicated staff added services to include documentation of the amount of food she ate at her meals. Staff also added weekly weights with parameters for when to notify the medical provided if her weight varied.

During an interview, a nurse manager said a family member of the client went to the facility and called emergency services (911) to take the client to the hospital, but the reason was unclear. The manager said hospital staff did not talk with her about the client's medical condition. The manager said she saw the client prior to her hospitalization and the client had no concerns other than she had pain when she urinated. The manager said the family member who took the client to the hospital, had not been involved in her care which resulted in court proceedings. The court determined a different family member should assist the client with her care needs.

The manager said the client could express her needs without difficulty and she made no allegations about staff withholding food or fluids from her. The client was able to feed herself without assistance and used adaptive utensils. The manager said the hospital discharged the client to a higher level of care, however the client returned to the facility one month later because she did not want a higher level of care. The manager said the conflict within the client's family which contributed to confusion over the client's hospitalization and re-admission. The manager said, upon the client's return to the facility, she made no allegations about staff withholding food or fluids from her. The client was able to feed herself and had food in her room. The manager said there were no complaints from the client, family, or medical providers about the care facility staff provided to her prior to her hospitalization. After the hospital stay, the facility added additional services to her plan of care. The services included monitoring her food intake and weights.

The client's family declined an interview.

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:
(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.

Vulnerable Adult interviewed: No, unable due to health.
Family/Responsible Party interviewed: No, Declined.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility added more services to the client including monitor her food intake and weights.

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 02/06/2024

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 February 5, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL033833949C/#HL033837385M. No correction orders are issued. On February 6, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL033832347C/#HL033836584M. No correction orders are issued.	0 000		