Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Avinity Home Care	HL20226005	May 4, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
7645 Lyndale Avenue South #110	8:45 a.m. to 4:30 p.m.	October 27, 2017
Facility City:	**Investigator's Name and Title:**	
Richfield	Kathleen Smith, DNP, RN, PHN, Special Investigator	

State:	ZIP:	County:
Minnesota	55423	Hennepin

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was abused when staff/alleged perpetrator restrained the client to a recliner chair.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse is substantiated. The alleged perpetrator (AP) unreasonably confined the client by restraining the client to a recliner chair with a gait belt.

The client received services from the home care provider, which was licensed as a comprehensive home care provider. The client received services of medication management, a secure living area, and assistance with activities of daily living. The client wandered, required frequent safety checks, and required redirection as to the location of the client's room. The home care provider implemented interventions of redirection and every 15 minutes safety checks. The home care provider staffed the area at night with one staff person, and staff had a walkie talkie to aid in communication. The client did not have orders for any restraints.

The night of the incident, the client was wandering around the facility. The next morning, the AP told two staff members s/he had used a gait belt to restrict the client's movements while the AP completed nightly tasks. The AP also sent a text message to another staff member, reporting s/he had used a gait belt to restrain the client to the recliner. During an interview with administration, the AP again stated the AP had restrained the client with a gait belt. According to staff interviews, the client did not have a change in behaviors or attitude after the incident.

During an interview, the family stated the facility had not informed them of the incident.

The AP had received vulnerable adult training and dementia training. Once the home care provider became aware of the allegation, the AP was placed on suspension and was terminated after further investigation.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The alleged perpetrator (AP) is responsible for the abuse. Although the AP had received training on how to redirect clients with dementia, and had received training regarding what actions constitute abuse, the AP chose to inappropriately restrain the client.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes

- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

Were residents selected based on the allegation(s)? ○ Yes ◉ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify:

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify:

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews:Four

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: ______

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ◉ Yes, date subpoena was issued September 7, 2(○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify ______

Observations were conducted related to:

☒ Personal Care

☒ Nursing Services

☒ Call Light

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Transfers

☒ Meals

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: ______

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Hermantown Police Department
Hermantown City Attorney
Saint Louis County Attorney

Protecting, Maintaining and Improving the Health of All Minnesotans

November 22, 2017

Administrator
Avinity Home Care
7645 Lyndale Avenue South #110
Richfield, MN 55423

RE: Complaint Number HL20226005 and HL20226006

Dear Administrator:

On November 1, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on October 4, 2017 with orders received by you on October 12, 2017. At this time these correction orders were found corrected.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Saint Louis County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20226	A. BUILDING: ______ B. WING ______	R-C **11/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVINITY HOME CARE	**7645 LYNDALE AVENUE SOUTH #110** **RICHFIELD, MN 55423**

(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 A licensing order follow-up was completed to follow up on correction orders issued related to complaints #HL20226005 and #HL20226006. Avinity Home Care was found in compliance with state regulations in relation to those cases.	{0 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8099

October 5, 2017

Ms. Jill Shewe, Administrator
Avinity Home Care
7645 Lyndale Avenue South #110
Richfield, MN 55423

RE: Complaint Number HL20226005 and HL20226006

Dear Ms. Shewe:

A complaint investigation (#HL20226005 and HL20226006) of the Home Care Provider named above was completed on October 4, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The 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 "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 statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

John Aglieco
Health Program Representative-Senior
Minnesota Department of Health
85 East Seventh Place, Suite 220
PO Box 64970
St Paul, MN 55164-0970
Office 651-201-4212 Fax: 651-281-9796

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Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20226	A. BUILDING: ______ B. WING ______	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order is issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On May 2, 2017, a complaint investigation was initiated to investigate complaints #HL20226005 and #HL20226006. At the time of the survey, there were 164 clients receiving services under the comprehensive license. The following correction orders are issued in relation to HL20226005.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	
0 325 SS=G	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 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	0 325		

Minnesota Department of Health

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0 325	Continued From page 1	0 325		

by:
Based on interview and document review, the home care provider failed ensure the client was free from maltreatment (abuse), for one of one clients (C1), when staff restrained C1 to a chair with a gait belt.

This practice resulted in a level 3 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 began receiving services in January 2017, with diagnoses of dementia and a right hip fracture. C1's New Resident Info Page, undated, indicated C1 wandered at night. The Registered Nurse Evaluation/Baseline Assessment for C1 noted C1 urinated in corners and other areas. An untitled, undated document indicated C1 had a behavior of wandering, and interventions included reminding C1 of the location of his/her room, as well as safety checks every fifteen minutes.

A document dated January 25, 2017, written by Unlicensed Personnel (ULP)-K, indicated ULP-S stated ULP-S had restrained C1 to a recliner.

During an interview on May 4, 2017, at 1:28 p.m., ULP-R stated ULP-S said that ULP-S used a gait belt to restrain C1 to the chair.

During an interview on May 4, 2017, at 12:58 p.m., Licensed Practical Nurse (LPN)-B stated C1

Minnesota Department of Health

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0 325	Continued From page 2 was easily redirected. LPN-B stated ULP-S had told LPN-B that ULP-S placed a gait belt around C1 in the chair, to prevent C1 from getting up and going to the bathroom. LPN-B also stated staff received eight hours of dementia training, and during monthly meetings staff are provided specific interventions to use. A review of a document with the phone number for ULP-S, undated and untimed, indicated a gait belt was used to restrain C1 to the recliner. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on interview and document review, the home care provider failed to report an incident of maltreatment for one of one clients (C1), when staff restrained C1 to a chair with a gait belt, but the incident was not reported for two days. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause 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:	0 805		

Minnesota Department of Health

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0 805	Continued From page 3 C1 began receiving services in January 2017, with diagnoses of dementia and a right hip fracture. C1's New Resident Info Page, undated, indicated C1 wandered at night. The Registered Nurse Evaluation/Baseline Assessment for C1 noted C1 urinated in corners and other areas. An untitled, undated document indicated C1 had a behavior of wandering, and interventions included reminding C1 of the location of his/her room, as well as safety checks every fifteen minutes. Review of a facility investigation document, dated January 25, 2017, indicated that on January 23, 2017, a staff member notified administration of confining C1 to a recliner with a gait belt. A nurse's note dated January 25, 2017, indicated a vulnerable adult report was made on January 25, 2017, regarding an incident involving C1. During an interview with administrative staff on September 7, 2017, at 1:31 p.m., it was stated s/he received notification of the incident involving C1 on January 23, 2017. Policy number 01-204 titled Vulnerable Adult Reporting and Investigation Policy, signed and dated December 1, 2015, indicates if maltreatment is suspected it must be reported to the registered nurse immediately, if neither the registered nurse or director are available the incident should be reported with-in a 24 hour period, lastly the witness may report the incident directly. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 805		