MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

Report #: HL20297041

Date: July 29, 2013

Date of Visit: March 4, 2013
Time of Visit: 9:30 a.m.-3:00 p.m.

By: Jolene Bertelsen, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that abuse occurred when a client was hit in the face by the alleged perpetrator (AP) (male staff/name unknown). When this was reported to administrative staff, the incident was not thoroughly investigated. In addition, the client is not receiving catheter care, skin monitoring, or fall prevention and monitoring in accordance with her service plan.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☑ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

A preponderance of evidence establishes that neglect occurred when the facility did not monitor or initiate care for a client's wound for four days after family notified staff that the client had a wound.

A review of the client's medical record established that the client is alert and oriented to self, and uses the wheelchair for mobility. The client was assessed to be a fall risk, and several interventions were implemented to prevent falls. The Customized Living Plan documents that the client receives AM and PM cares, transferring assistance to/from meals, catheter care, and safety checks every hour at night.

According to an interview with the facility nurse, the client was admitted to the facility with a red area on his/her "bottom." No documentation of the red area or monitoring of the red area was noted in the medical record. The facility Resident Notes and nurse interview revealed that, on Monday, a resident care attendant informed his/her of an open area on client #1's coccyx, and assessed the area to be 1.5 cm long x 0.2 com deep, with a small amount of drainage noted. The physician and wound nurse were notified that day. The wound nurse evaluated the wound on Tuesday, and initiated a treatment plan. When assessed by the wound nurse, the wound was noted to be a stage II measuring: 2.0cm x 0.5cm 0.3cm. The nurse denied that she was told by a family member of the open area.

A family member of the client was interviewed and stated that s/he notified the nurse of an open area on the client's coccyx on a Thursday. The family member stated that the wound was not observed or assessed by the nurse at the facility until the following Monday, and a treatment plan for the open area was not implemented until the following Tuesday. The family member stated the wound appeared much deeper than observed four days previously.

A preponderance of evidence that a client was abused is inconclusive. Although the allegation is that a male staff person hit a client, interview and documentation review established conflicting information regarding the incident.

On the day of the alleged abuse, the client reported to her therapist that a male staff person slapped her/him in the face. The therapist reported the incident to administrative staff. The nurse interviewed the client who gave a

differing account of the incident, and assessed the client for injuries, with no injuries noted.

During the course of the investigation, several staff who worked with the client on the day of the alleged incident were interviewed. Two staff stated that the client did not express concerns to them regarding being slapped. The client was visited, but declined to be interviewed on the day of the site investigation.

Additional concerns regarding adequate cleaning of the client's catheter, and fall prevention were reported.

A review of the client's medical record revealed that the client has a catheter in place. The client's record included orders for daily cleaning of the catheter bag. Several staff verified that they were trained on the procedure for cleaning of the catheter bag, and step by step instructions are hanging on the wall of the client's bathroom. On the day of the site visit, the client's catheter bag was hanging in the bathroom, with a cap on the bag. In addition, interviews verified the correct procedure for changing and cleaning of the catheter bag. No concerns were noted on the day of the site visit.

The client had several falls while at the facility. According to the Service Plan, staff is to conduct safety checks every hour at night. During the day and evening shifts, the daily assignment sheet documents a care schedule including a toileting, escort, eating, rest and activity schedule. The facility initiated several interventions to prevent falls with the client, including a physical therapy evaluation, and a walking program. Although the client had several falls at the facility, interview and documentation review established that staff followed the client's service plan, and initiated interventions to prevent falls from occurring.

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 facility staff did not assess or implement a monitoring plan to address skin care needs of a 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 Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) – Compliance Met

The facility was found to be in compliance with State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665). No state licensing orders were issued.

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 If no, specify: _____
(State licensing orders will be available on the MDH website.)

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"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.

The Investigation included the following:

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

☒ Medical Records

☒ Medication Administration Records

☒ Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☒ Therapy and/or Ancillary Services Records

☒ Skin Assessments

☒ Care Guide

☒ Treatment Sheets

☒ Physician Progress Notes

☐ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☐ Weight Records

☒ Assessments

☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☒ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☐ Call Light Audits

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

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 complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, 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: The client declined to be interviewed.

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 9

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator was identified in the complaint.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Wound Care	☐ Medication Pass	☐ Meals
☒ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☒ Use of Equipment	☒ Transfers	☐ Incontinence
☒ Call Light	☐ Other: _____	

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: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Robbinsdale City Police Department
Hennepin County Attorney
Robbinsdale City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: _____ B. WING _____	C 05/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERFIELD HILL PHASE II	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

(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 complaint investigation was initiated on 3/4/2013 to investigate case #HL20297041. The following correction order is issued.	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 are the Suggested Method of Correction and 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person	0 030		

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0 030	Continued From page 1 who receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure that a client received skin monitoring care and services according to accepted nursing standards for one of one client's (C1) reviewed. Findings include: C1's medical record was reviewed and indicated that C1 has diagnoses including dementia. C1 requires assistance from staff for cares. A review of the Resident Notes, dated 1/21/2013 revealed that C1 reported to a staff person that her "bottom" hurt. Employee (G)/Resident Care Attendant/(RCA) reported to Employee (F)/Registered Nurse/(RN) that C1 had an open area in his/her coccyx area and redness to the left folds of the abdomen. On 1/22/2013, a wound nurse assessment documented a 2.0cm x 0.5cm x 0.3cm stage II pressure ulcer on C1's coccyx. No additional skin monitoring or documentation was noted in the Resident Notes. Employee (G) was interviewed on 3/12/2013 at 12:55 p.m. and stated that on 1/21/2013, she was	0 030		

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0 030	Continued From page 2 assisting C1 with evening cares, and C1 stated that her "bottom" hurt. She observed a red sore, approximately the size of a dime on C1's coccyx area. She covered the area with a gauze dressing, and wrote a note in the communication book and a note to employee (F). Individual (E) was interviewed on 3/11/2013 at 9:30 a.m. and stated that on 1/17/2013, she reported to employee (F) that she observed an open area on C1's coccyx, and talked with employee (F) regarding an assessment of the area. When asked again four days later, employee (F) told individual (E) that she had not assessed the open area yet, but stated that a wound nurse was coming to assess at the open area and initiate treatment on 1/22/2013. Employee (F) was interviewed on 3/11/2013 at 8:06 a.m. and stated that C1 came to the facility with a red spot on her "bottom." She stated that employee (G) found the area had opened during cares on 1/21/2013. Employee (F) assessed the area on 1/21/2013, and noted a 1.5cm long x .02 cm deep open area on C1's coccyx. An outside agency was notified to assess and treat the open area on 1/22/2013. Employee (F) stated that nursing staff are notified of any skin concerns by the Resident Care Attendants/(RCA), and staff will document in the medical record only if skin issues are found on a client. She verified that the nursing staff does not complete skin assessments unless notified by the RCA's of any skin concerns. An email, dated 1/21/2013 written by individual (E) verifies that she spoke with administrative staff regarding the open area on the client's coccyx on 1/17/2013, and when asked again about the open area on 1/21/2013, was told that	0 030		

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0 030	Continued From page 3 the nursing staff of the facility had not assessed the open area, but was told that they notified a wound nurse to come to the facility to assess and treat the coccyx wound on 1/22/2013. Although employee (G) stated that C1 came to the facility with a red spot on her "bottom," there was no documentation that the area was monitored by facility staff, or that the staff assessed or treated the area. In addition, on 1/17/2013, when notified by individual (E) of the open area, the facility staff did not complete an assessment or treatment of the wound for four days. The wound nurse completed an assessment on 1/22/2013, and documented the open area as a stage II pressure ulcer approximately 2.0cm x 0.5cm x 0.3cm. A treatment plan was initiated at this time. TIME PERIOD FOR CORRECTION: Thirty (30) days.	0 030		
0 605	626.557 Subd.3 Timing of report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility	0 605		

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0 605	Continued From page 4 from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	0 605		

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0 605	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report suspected maltreatment of a vulnerable adult in a timely manner to the common entry point for one of one client's (C1) reviewed. Findings include: A review of the facility's internal investigation revealed that on 1/17/2013, C1 reported to facility staff that a male staff person hit her in the head while assisting her out of bed in the morning. The incident was investigated and found to be inconclusive. No injuries were noted to C1.The facilities internal investigation indicated the Common Entry Point (CEP) was notified regarding the suspected maltreatment on 1/18/2013, no time documented. Employee (F) was interviewed on 3/11/2013 at 8:06 a.m. and stated that she completed an internal investigation regarding the allegation of abuse and interviewed staff and C1. The investigation was found to be inconclusive. Employee (F) stated that the incident was reported to the CEP, unsure of exact date. Although the internal investigation report documents that the CEP was notified, the CEP did not have an incident report on file for this incident. The facility's Vulnerable Adult Reporting and	0 605		

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0 605	Continued From page 6 Investigation Policy indicated that when maltreatment is suspected, the registered nurse should immediately make an oral report to the common entry point. The policy defined that "immediately" meant as soon as possible, but no longer than 24 hours from the time staff had knowledge that the incident had occurred. TIME PERIOD FOR CORRECTION: Thirty (30) days.	0 605		

MINNESOTA
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up
PUBLIC DATA

Facility:
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

Report #: HL20297041

Date: January 15, 2014

Date of Visit: January 14, 2014
Time of Visit: 9:30 a.m.

By: Jolene Bertelsen, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up two state licensing order(s) which were issued on June 11, 2013, as the result of an investigation which had been completed on May 24, 2013.

The status of each order is as follows:
1 144A.44 Subd.1(2) - Corrected
2 626.557 Subd.3 - Corrected

xc: Minnesota Department of Health – Licensing and Certification

AH Form Approved
1/21/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H20297	A. Building B. Wing	1/14/2014

Name of Facility	Street Address, City, State, Zip Code
COPPERFIELD HILL PHASE II	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 01/14/2014	ID Prefix 00605 Reg. # 626.557 Subd.3 LSC	Correction Completed 01/14/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By KL/AK	Date: 01/21/2014	Signature of Surveyor: 25574	Date: 01/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/24/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES NO