MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
The Gardens at St. Gertrudes
1850 Sarazin Street
Shakopee, MN 55379
Scott County

Report #: HL23871003

Date: February 10, 2015

Date of Visit: August 6, 2014
Time of Visit: 4:00 a.m. - 11:30 a.m.

By: Diane Wallner, 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 a client was neglected when the client eloped from the facility during the night and had a fall with injuries. The client had a history of wandering; however, was only monitored during the night every four hours.

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:

Based on a preponderance of evidence, neglect of supervision leading to a client eloping from the facility during the night and sustaining a fall with serious injuries is substantiated. Although the client had other medical concerns, which led to a brain aneurysm, the facility did not ensure supervision for the client's safety.

The client was admitted to the facility following a hospital stay for an aneurysm (bleeding in the brain). The client had resulting difficulty speaking and increased, intermittent confusion. The client was noted to wander during the hospital stay. The client ambulated independently with cues for direction. Upon admission to the facility, the service plan did not note the client had a history of wandering but did note staff were to check the client every four hours and at 11:00 p.m. and 3:00 a.m.

Six days after the client was admitted to the facility, the client was confused and attempted to elope during an evening shift. Staff intervened, redirected the client, and contacted their supervisor. Family was notified and spent the night with the client. The nurse e-mailed the staff that the client had wandered the previous evening by the front door. Staff was instructed to keep an eye on the client. No other specific direction was provided. The client had no elopement attempts on the seventh day. The seventh night, staff checked on the client at approximately 11:00 p.m., and the client was asleep. When staff went to check on the client at approximately 3:00 a.m., staff could not locate the client in the client's apartment. Staff searched in the building for the client, in the assisted living, the nursing home area, and the hospital area. They were unable to locate the client.

During the search for the client, a staff member from the adjoining hospital found the client lying on the ground outside of the facility at the edge of the parking lot and called the police. The police came to the facility and staff identified it was the client who was missing. The client had been found lying on the ground unconscious with a heavy bleeding head wound.

Emergency response transferred the client to the emergency department. A CT scan of the client's head showed a large subdural hemorrhage (bleeding on the brain) and an intraparenchymal (bleeding into the brain tissue caused by trauma) hematoma (raised blood filled bump on the head). Hospital notes indicated the client had probably sustained another aneurysm prior to the elopement and fall.

Review of the facility video monitoring footage showed the client walked out of his/her apartment door, down the hallway towards the hospital and around through part of the nursing home. The client then walked out of the front door of the facility at 12:16 a.m. This route did not take the client past the facility nursing stations and staff did not see the client exit the apartment or building. The client was outside that night for almost three hours.

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 failed to ensure that a client received the necessary supervision for safety. The facility did not have policies and procedures related to clients who wander. The facility did not provide direction or interventions to staff for supervision of a newly admitted client who was assessed as a risk for wandering.

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 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): A follow-up survey to the correction orders issued as a result of the complaint investigation was completed on December 5, 2014. Based on interviews, observation and document review, the orders were found to be corrected.

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; and

The Investigation included the following:

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

☒ Medical Records
☒ Care Guide
☒ Medication Administration Records
☒ Treatment Sheets
☒ Facility Incident Reports
☒ Physician Progress Notes
☒ ADL (Activities of Daily Living) Flow Sheets
☒ Laboratory and X-ray Reports
☒ Physician Orders
☒ Social Service Notes
☒ Nurses Notes
☐ Meal Intake Records
☒ Activities Reports
☐ Weight Records
☐ Therapy and/or Ancillary Services Records
☒ Assessments
☒ Skin 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

☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☒ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: _____

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: Although there were no other clients who eloped, some clients who had falls were selected, in addition to other current clients

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

○ Yes ◉ No ○ N/A Specify: the client was hospitalized

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: Unable as the client was hospitalized

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 5

Interview with staff: ◉ Yes ○ No ○ N/A Specify: 2 additional staff were spoke with during the onsite tour and observations

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 5

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner 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 _____ ○ 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: staff interaction with clients; staff response to client needs	

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: Photos of the route travelled by the VA to elope from the facility to where the fall occurred outside at the parking lot

xc: Health Regulation Division – Home Care Assisted Living Program
Minnesota Board of Nursing
Shakopee City Police Department
Scott County Attorney
Shakopee 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
	H23871	A. BUILDING: _____ B. WING _____	C 08/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT ST GERTRUDES	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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 to investigate complaint #HL23871003. The following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220; St. Paul, Minnesota 55164-0970.	0 000		
06155	4668.0825 Subp. 2. Nursing Assessment and Service Plan This MN Requirement is not met as evidenced by: Based on document review and interview the facility failed to develop a service plan to provide services according to the needs for 1 of 1 client (C1). Findings include: Review of the medical record for C1 revealed C1 was admitted to the facility within 14 days of the incident. Progress Notes, dated 7/17/14 at 4:05 p.m., noted: "Last evening....Resident got up about 10:15 PM, got dressed and attempted to leave the building and was resistive to redirection. After several attempts to redirect, family was called and son came and spent the night with her...." The next progress note entry, dated 7/18/14 at 5:02 a.m., noted: "Call received at 3:30 this morning stating the resident was not in her room or seen within the building at the time. Charge	06155		

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06155	Continued From page 1 nurse from St. Gertrude's had been informed. Shortly thereafter campus security called that resident had been found outdoors near the parking lot with head wound and was being transported to [sic] ER via ambulance.... " Review of the medical record for C1 revealed the RN Assessment Tool, dated 6/26/14, which noted two areas checked that included information about the client: "C. Wandering (Q7) Wanders and requires moderate redirection or needs increased checks for whereabouts during waking hours (checked); Wanders and requires moderate redirection or needs increased shift checks during sleep time hours (checked)." X A review of the Nursing Discharge Criteria, signed 7/10/14, noted: "7. Resident wanders in and out of building without regard to own safety." An email for staff reference was sent to facility administration regarding the notes from 7/17/14 and C1 that noted: She was wandering last evening by the front door. Please keep an eye on her tonight. Her family will be in and out checking on her as well...." A observational tour and interview was conducted with the home care manager on 8/6/14 at 7:06 a.m. The home care manager stated the assisted living facility does not accept clients who wander as there is no secure unit. A second interview was conducted with the home care manager on 8/6/14 at 9:48 a.m. and she stated C1 had a wanderguard while at the hospital prior to her admission to the facility. The home care manager stated she spoke with C1's family about questionable safety the day before the incident because C1 had attempted to wander	06155		

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06155	Continued From page 2 before the client was found outside. The home care manager verified there would be no one was at the main entrance desk to see C1 if she would wander during nighttime hours. An interview was conducted with nursing assistant (NA)-E on 8/6/14 at 4:35 a.m. and she stated communication and care plan information are available for staff to review. Although NA-E worked a couple of times with C1 and did not work the night of the incident, she was not aware C1 wandered. A review of the Nursing Admission and Continued Stay Criteria, dated 7/1/11, noted: 1. A pre-admission assessment by a Registered Nurse of each applicant's functional level will be acquired by the admissions team to determine the service needs of the applicant, and whether or not the applicant can be adequately served by the facility. The admissions team will make all admission determinations following the outcome of the assessment to assure the facility is able to meet the applicant's needs." Time Period for Correction: Thirty (30) Days	06155		

AH Form Approved
12/9/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H23871	A. Building B. Wing	12/5/2014

Name of Facility	Street Address, City, State, Zip Code
THE GARDENS AT ST GERTRUDES	1850 SARAZIN STREET SHAKOPEE, MN 55379

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 06155 Reg. # 4668.0825 Subp. 2. LSC	Correction Completed 12/05/2014	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
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/22/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO