DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Traditions of Owatonna			HL24247022	November 24, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
195 24th Place Northwest			9:45 a.m. to 6:00 p.m.	February 7, 2018
Facility City:			**Investigator's Name and Title:**	
Owatonna			Kathleen Smith, DNP, RN, PHN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55065	Steele		

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged a client was neglected when the facility staff/alleged perpetrator #1 and #2, did not initiate cardiopulmonary resuscitation when the client was found with no pulse and was not breathing. The client's code status was full code.

☒ 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 the evidence, neglect is substantiated. Home care provider staff failed to provide cardiopulmonary (CPR) resuscitation to the client when indicated, according to documented client wishes.

The client received services from a provider licensed as a comprehensive home care provider, including medication management, safety checks, and diabetic monitoring. The client's care plan had been reviewed just over a month before the incident, and indicated the client had an order for CPR but not intubation. A 90 Day Service Evaluation dated the month before the incident indicated the client was oriented to person, place, and time. Additionally, the document indicated the client did not require two people to assist with transfers or the use of a mechanical lift. The Individualized Service Plan, also dated the month before the incident, and signed by the client, indicated the client was a full code, meaning the client should receive CPR if indicated by the client's condition.

During an interview, member of direct care staff stated the client was discovered about 8:10 p.m. on the day of the incident, and found to have: cold, clammy white skin, and no pulse or respirations. The direct

care staff member was CPR certified but did not initiate CPR. The direct care staff member stated that staff had itineraries (assignment sheets) that indicated when care to provide to each client, but did not indicate the code status.

During an interview, a nurse stated the direct care staff member requested assistance at about 8:15 p.m. When the nurse arrived in the client's room, the client appeared colorless, with eyes open and no pulse. Emergency medical services were called. The nurse was CPR certified but did not initiate CPR. The nurse stated s/he was unable to move the client from the recliner to the floor to initiate CPR, stating the client did not have a mechanical lift. The nurse was not aware of the code status for the client and had to return to the office to obtain the information. The nurse was not aware the information was in the electronic system.

An interview with nursing management indicated staff were expected to initiate CPR when indicated. It was also stated the itineraries or assignment sheets include the code status for each client: this was observed by this investigator. Additionally, management stated there is a mechanical lift available to use for any client.

According to a law enforcement document, when police arrived, the client's hands were cold, however the client's arms and body were warm. Emergency medical services arrived and were told the client was not to receive CPR However, the nurse then went to the office to check, and upon returning, stated the client was a full code. CPR was then initiated by emergency services. The client was pronounced dead at 8:44 p.m.

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 facility is responsible for the neglect, because although it admits clients who have the expectation of CPR initiated by home care provider staff, the home care provider did not have clear expectations of staff in the provision of CPR. In addition, both direct care staff and the available nurse were unable to rapidly and accurately determine the client's code status, resulting in inaccurately telling emergency medical services that the client did not want CPR, further delaying resuscitation.

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 Met
The facility was found to be in compliance with State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483). 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

(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 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

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction 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] Care Guide
- [x] Nurses Notes
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan
- [x] Other, specify:

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [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: deceased

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: Five

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Three

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 ○ 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
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ 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: By law enforcement

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Steele County Medical Examiners

Owatonna Police Department

Steele County Attorney

Owatonna City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H24247	A. BUILDING: _____ B. WING _____	C 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA	195 24TH PLACE NW OWATONNA, MN 55060

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are 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 October 24, 2017, a complaint investigation was initiated to investigate complaint #HL24247022 . At the time of the survey, there were 39 clients receiving services under the comprehensive license. The following correction orders are 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 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	0 325		

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0 325	Continued From page 1 forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the home care provider failed to keep one of one clients (C1) free from maltreatement (neglect). The home care provider staff failed to know the code status of the client and provide cardio-pulmonary resuscitation (CPR) to the client when indicated. This practice resulted in a level three 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 is 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 that a situation has occurred only occasionally. The findings include: The client received services from the home care provider since 2013, including medication management, safety checks, and diabetic monitoring. The care plan had been reviewed on September 27, 2017, and revealed the client had an order for CPR but not intubation, and it is not documented the client required assistance making decisions. A 90 Day Service Evaluation dated September 27, 2017, indicated the client was oriented to person, place, and time. Additionally, the document indicated the client did not require two people to assist with transfers or the use of a mechanical lift. The Individualized Service Plan, dated and signed by the client on	0 325		

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0 325	Continued From page 2 September 27, 2017, indicated the client was a full code, meaning CPR should be initiated if indicated by the client's condition. During an interview with Unlicensed Personnel (ULP)-J, on October 24, 2017, at 4:41 p.m., it was revealed the client was discovered about 8:10 p.m., and found to have cold, clammy white skin, and no pulse or respirations, but ULP-J did not initiate CPR. ULP-J was CPR certified. ULP-J stated staff have itineraries that provide needed care information for each client, but not the code status. During an interview with Licensed Practical Nurse (LPN)-A on October 24, 2017, at 3:58 p.m., stated ULP-J requested assistance at about 8:15 p.m. on the day of the incident. When LPN-A arrived in the client's room, the client appeared colorless, with eyes open and no pulse, ULP-J was instructed to call emergency services. LPN-A was CPR certified. LPN-A was unable to move the client from the recliner to the floor to initiate CPR, stating the client did not have a mechanical lift. LPN-A was not aware of the code status for the client and had to return to the office to obtain the information, the LPN was not aware the information was in the electronic system and CPR was not initiated. An interview with nursing management on November 24, 2017, at 5:23 p.m., noted staff were expected to initiate CPR or follow the instructions given by emergency services. The itineraries or assignment sheets include the code status for each client: this was observed by this investigator. Additionally, management stated there is a mechanical lift available to use for any client.	0 325		

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0 325	Continued From page 3 According to a law enforcement document, upon police arrival on October 20, 2017, at 8:17 p.m. the client's hands were cold, however the client's arms and body were warm. Emergency services arrived and were told the client was not to receive CPR. LPN-A then went to the office to check, and returned stating the client was a full code. CPR was initiated by emergency medical services and the client was pronounced dead at 8:44 p.m. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 325		