MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Garden Court Chateau	HL24912004	April 7, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
2501 Country Road 76	8:00 a.m. - 4:00 p.m.	September 25, 2017
Facility City:	**Investigator's Name and Title:**	
Grand Rapids	Rhylee Gilb, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55744	Itasca

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that client was abused when the AP forced a client to take medications against his/her will by straddling him/her, holding his/her head and forcing medication by hand into his/her mouth. The client became agitated and bit the AP.

In addition, it is alleged the facility neglected the same client when the client experienced two major fall incidents with head injury and the staff failed to re-assess the client. The client died eight days after the second serious fall due to a closed head injury.

☒ 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, neglect is substantiated. The home care provider failed to complete assessments or implement interventions for the client after multiple falls. Based on a preponderance of evidence, abuse is also substantiated. The alleged perpetrator (AP) forced the client to take medications against the client's will.

The client was admitted with diagnoses that included dementia. Upon admission to the home care provider, the client required stand by assistance with transfers, but was able to independently ambulate with his/her walker. In addition, the client received assistance with activities of daily living and medications. The client had a history of falls and had continued high risk of falls due to gait instability and confusion. Initial fall interventions included, non-skid shoes, call light within reach and staff to check for unmet needs.

Approximately three weeks after the client began receiving services, the client experienced two falls, one included a laceration to the head. The client also had a low pulse, one as low as 46 beats per minute. The next day, the physician recommended the client go to the emergency department (ED) for evaluation of bradycardia (low heart rate). The client received intravenous fluids for dehydration and was sent back to

the home care provider. No follow-up assessment or continued pulse monitoring was completed, and no fall interventions were added to the care plan.

Two weeks following the first emergency department visit, at 2:00 a.m., the client experienced a fall from bed with a head injury. A nurse applied a dressing to the client's right elbow and right knee. A nurse and a caregiver assisted the client back into bed. At 8:00 a.m., the client was difficult to arouse and staff sent her/him to the ED. The client had multiple bruises throughout his/her body and dried blood on his/her nose and between his/her eyebrows. A computed tomography scan showed a closed head injury. The client's family declined intervention, a hospice referral was made, and the client was returned to the home care provider. A significant change assessment was not completed by a nurse upon the client's return. The next day, the client started hospice and died seven days later.

The client's death record indicated cause of death was related to a fall with a closed head injury.

One evening, the client was agitated and staff brought the client to the living area for close observation. The AP attempted to give the client medication, but the client kept clenching his/her mouth and turning his/her head away in refusal. The AP stood in front of the client, held his/her head in the AP's arm, forcibly put the medications into the client's mouth and put his/her fingers into the clients mouth to make the client swallow the medication. The client became more agitated, tried to fight, and bit the AP's finger.

During an interview, a staff member said s/he witnessed the AP stand in front of the client, hold his/her head in the AP's arm, forcibly put the medications into the clients mouth and put his/her fingers into the client's mouth to make the client swallow the medication. Another client reported observing the same incident.

The client's medication administration record showed the AP gave the client medications.

During an interview, a registered nurse (RN) stated failing to complete assessments was an oversight. The RN said the AP had come to work intoxicated and was placed on a leave of absence to complete treatment. The facility did not ask for evidence of treatment completion when the AP returned to work, and allowed the AP to return to her previous position. The forced medication incident was not reported until six months after the incident, because others feared the AP would retaliate. Once the AP gave notice of ending her/his employment and went on vacation, the staff member and another client reported the incident. The AP was not allowed to return to the facility.

During an interview, the client's family member stated the client was able to ambulate at admission, but was wheelchair bound after the first fall. The family member said the client had cognitive impairments but was able to express likes, dislikes and some needs. The family member stated the client had a tendency to be combative towards people s/he did not like and expressed s/he did not like the AP who worked on the

night shift. The family member stated s/he was not aware of any physical abuse; however, the client's body was covered with multiple bruises which she thought were from falls.

During an interview, the AP stated s/he did not force the client to take medication and did not remember that the client took any medications on the night shift.

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 multiple staff members failed to assess the client or implement new interventions when the client had repeated falls, bradycardia, and dehydration. The alleged perpetrator (AP) and facility are both responsible for the abuse. The AP, a licensed nurse, was educated about proper medication administration and had vulnerable adult training, yet physically forced the client to take medications. The facility was aware of the AP's substance abuse issues and failed to ensure the AP was safe to work before allowing the AP to return to direct care and leadership responsibility.

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:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(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;

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

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] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

☒ Other, specify: grievances

Number of additional resident(s) reviewed: Two

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: client is deceased

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:

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: Five

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:

☒ Call Light

☒ 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: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Itasca County Medical Examiners

Grand Rapids Police Department

Itasca County Attorney

Grand Rapids City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 13, 2017

Ms. Julie Manley-Hartje, Administrator
Garden Court Chateau
2501 County Road 76
Grand Rapids, MN 55744

RE: Complaint Number HL24912003 and HL24912004

Dear Ms. Manley-Hartje :

On November 9, 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 September 25, 2017 with orders received by you on October 12, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

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
Itasca County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H24912	A. BUILDING: _____ B. WING _____	R-C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2501 COUNTY ROAD 76 GRAND RAPIDS, MN 55744

(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 HL24912003 and HL24912004. Garden Court Chateau was found in compliance with state regulations.	{0 000}		

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

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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(s) has been 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 April 7, 2017, a complaint investigation was initiated to investigate complaints #HL24912003 and HL24912004. At the time of the survey, there were 24 clients that were receiving services under the comprehensive license. The following correction orders are issud.	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 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (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 by: Based on interview and document review, the licensee failed to ensure freedom from maltreatment for one of three clients (C2) reviewed. C2 was neglected related to falls and was abused when the client was forced to take medication. This practice resulted in a level four violation (a violation that results in 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: C2's medical record was reviewed. C2 was admitted to the home care provider on 6/10/16 with diagnoses that included dementia. C2's service plan, dated 6/10/16, indicated C2 required assistance with medication administration, bathing, supervision, assistance with dressing/grooming, and assistance with transferring as needed. C2's initial registered nurse (RN) assessment, dated 6/10/16, indicated C2 required assistance with transfer due to safety and used a walker for transfers within his room and a wheelchair to transport to the dining room or living area. C2 was also independent with toileting. In addition, C2's nurse's note dated 6/10/16 indicated upon admission, C2 was ambulating with a walker, independent with activities of daily living, however experienced sun	0 325		

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0 325	Continued From page 2 down syndrome and required assistance to address needs during that time. In addition, the RN assessment indicated C2 had a history of falls, and interventions on the care plan dated 6/12/16 included non-skid shoes, call light in reach, check for unmet needs, and stand-by assist with ambulation. C2's nurse notes indicated on 6/28/16, the night licensed practical nurse LPN-C documented that C2 experienced a fall. LPN-C found a skin tear, a "badly bruised" right elbow, and a rug burn on C2's right knee. C2's skin tear was bandaged and C2 was assisted back to bed. An incident report revealed at 2:45 p.m. on 6/28/16, C2 experienced a second fall with his walker and sustained a cut above his right eye and right elbow. A fax dated 6/28/16, showed RN-A updated C2's physician regarding the incident and pulses of 46 beats per min (bpm) and 50 bpm. The physician ordered C2 to be evaluated in the emergency department (ED) for bradycardia (low heart rate) on 6/29/16. C2's hospital record dated 6/29/16, C2 was evaluated in the ED. C2 was given 500 milliliters (mL) of intravenous fluids for mild dehydration. C2 had a CT (computerized tomography) scan of the brain related to his head injury, with negative findings. There was no medication changes; C2 was to continue the current dose of lisinopril (blood pressure medication) of 20 milligrams (mg) daily. C2 returned to the licensee the same day. C2's medical record lacked any nurses notes regarding a return from the ED. In addition, there was no record found of a RN assessment or evaluation upon return from the ED, nor an update to the care plan for fall interventions. In addition, C2's record lacked any further records	0 325		

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0 325	Continued From page 3 related to the history or monitoring of the bradycardia. C2's record lacked any nurse notes from 6/28/16 through 7/13/16. A hospital record dated 7/13/16 was reviewed. C2 was evaluated again in the ED. The ED dictation indicated the licensee reported a fall occurred 2:00 a.m. on 7/13/16. Staff assisted C2 back into bed, placed a chair next to the bed to prevent C2 from falling out of bed, and completed a check on him every hour. At 8:00 a.m., staff reported C2 was difficult to arouse, so C2 was sent to the ED. The hospital record dictated physical evaluation of C2 revealed multiple bruising throughout his body, a dressing to his right elbow and right knee, and dried blood on his nose and between his eyebrows. Another CT scan was completed and C2 was diagnosed with a closed head injury. Family declined intervention, a hospice referral was made, and C2 was returned to the home care provider. C2's nurse note indicated hospice intake was completed on 7/14/16. However, C2's record lacked an RN assessment for a significant change related to an enrollment in hospice. C2's nurse notes indicated two more additional falls occurred on 7/14/16 and 7/15/16. No new interventions were documented. C2 died on 7/21/16, and C2's death record indicated the primary cause of death was falls with a closed head injury. An interview on 4/7/17 at 10:00 a.m., LPN-B stated RN-A had only completed assessments on clients yearly and a related licensing order had	0 325		

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0 325	Continued From page 4 been recently issued by the State Survey team. During an interview with RN-A on 4/11/17 at 12:15 p.m., RN-A mentioned failure to update assessments had been an oversight. RN-A also indicated prior to the State Survey in March 2017, she had been working two days week, but available by phone as she is the only RN for the facility. The licensee policy for RN assessments was requested, but not provided. C1 stated she witnessed LPN-E force C2 to take medications. C1 stated C2 could not talk, but was trying to express something when LPN-E attempted to give C2 his medications. C1 explained LPN-E was yelling and swearing at C2, because C2 refused to take his medication. C1 stated LPN-E stood in front of C2, put her arm around his head, and tried to get the medications into C2's mouth with her fingers while C2 was gagging. C1 stated unlicensed personnel (ULP)-D also worked that night and LPN-E yelled at ULP-D when she tried to intervene. On 4/11/17 at 1:10 p.m., C2's family member stated when C2 was admitted, C2 was ably to verbally express likes and dislikes. The family member stated C2 had stated he did not like the "big one at night", referring to staff member LPN-E on the night shift, but could not express why. The family member stated, at the second emergency room visit on 7/13/17, C2 was no longer able to verbally communicate. During an interview on 4/11/17 at 2:20 p.m., ULP-D stated she was unsure of the exact date,	0 325		

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0 325	Continued From page 5 but thought approximately a week or two prior to C2's death, she had witnessed LPN-E forcefully administer medications to C2. ULP-D stated it was during the night shift, and C2 had some behavioral issues, therefore he was brought into the day room for closer observation by staff. ULP-D stated LPN-E crushed C2's medications into a powder and approached C2 with the medications. ULP-D stated C2 had clenched teeth, refused to open his mouth, and shook his head "no" at LPN-E. ULP-D stated LPN-E then placed her head behind C2's head to hold it steady, forced the medications into C2's mouth and rubbed the medications into C2's cheeks with her fingers. C2 bit LPN-E in reaction, ULP-D added. The staff schedule was reviewed. After C2's hospice admission, the only date ULP-D and LPN-E both worked the night shift was 7/17/16. C2's "as needed" MAR for July 2016 was not found in the medical record. During an interview on 4/11/17 at 1:50 p.m., LPN-E stated she never forced C2 to take medications. The licensee policy titled "Medication Management Procedure," dated 8/15/15, indicated if a client refused medication, the nursing staff must document in the medication record the reason why and any follow up procedures to meet the client's needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		