Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Villa Court
1220 Villa Court Drive
Cromwell, MN 55726
Carlton County

Report #: HL26451003

Date: January 21, 2016

Date of Visit: August 3 & 4, 2015
Time of Visit: 10:40 a.m.-4:30 p.m.
7:00 a.m.-12:30 p.m.

By: Jane Aandal, R.N., Special Investigator

Type of Facility:

☐ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☒ Other: Comprehensive Home Care Provider

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a client was neglected when s/he was dropped from a lift due to equipment failure and suffered skin tears and bruising. Later, the same day, a different mechanical lift failed and the client suffered an additional skin tear.

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 is substantiated when the client sustained two skin tears in one day from two different EZ stands (a device to assist the client to a standing position). A preventative maintenance program was not in place and monthly safety checks were not completed.

The client was diagnosed with a stroke, dementia, and arthritis. The client's care plan directed two staff to transfer the client to the toilet with the EZ stand. The client's care plan was followed at the time of both incidents.

The morning of the first incident, a staff person was going to raise the client up from the toilet with the EZ stand. As the other staff person pushed the button on the EZ stand to raise the client up, the actuator (the main mechanism that lifts the client to a standing position) failed and the client fell back onto the toilet. The client received a skin tear 1 centimeter (cm) by 2 cm to the top of his/her right hand and a bruise to the left forearm 3 cm by 8 cm. The skin tear on the right hand required a protective dressing which was checked daily and changed as needed.

On the evening of the second incident a staff person was getting the client ready to bring to the toilet. The staff placed the right strap of the sling to the EZ stand. When the staff was about to place the left strap to the EZ stand the actuator failed. The client received a skin tear on the left forearm 8 cm by 3.5 cm. The skin tear on the left forearm was cleansed, triple antibiotic ointment was applied along with a non-stick dressing and wrapped with gauze daily

Staff interview revealed the actuator looked like it was worn through. In addition, no preventative maintenance had been completed on the EZ stands.

The facility indicated the actuator of both EZ stands had broken. The manufacturer's instructions indicated the actuator should be checked monthly and lubricated. Interviews verified that this was not done for either of the EZ stands.

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 have policies and procedures in place for the preventative maintenance of the EZ stands. In addition, the facility failed to ensure monthly preventative maintenance was completed on the EZ stands.

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):

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

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

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: 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: ________

<u>Interviews:</u> 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 to be interviewed due to dementia

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: 13

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: not identified

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: skin tear treatment	

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: The broken actuator on the EZ stand

xc: Health Regulation Division – Home Care Assisted Living Program
Carlton County Sheriff's Department
Carlton County Attorney
Cromwell 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
	H26451	A. BUILDING: ______ B. WING ______	C 08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

(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, 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 August 3, & 4, 2015 a complaint investigation was initiated to investigate complaint #HL26451003. At the time of the survey, there were 59 clients that were 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 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.	
0 325	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		

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

Minnesota Department of Health

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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 observation, interview and document review, the licensee failed to ensure that 1 of 1 client (C1) was free from maltreatment-neglect when the client sustained two skin tears in one day from two different EZ stands (a device to assist the client to a standing position) that broke. The licensee failed to have a preventative maintenance program in place for the EZ stands so monthly safety checks were not completed. 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), and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed. C1 was diagnosed with a past stroke, dementia, and arthritis. C1's care plan dated 5/1/15, indicated the staff transferred C1 with the EZ stand for all transfers. C1's Service Plan Agreement dated 5/1/15, indicated C1 would receive staff assistance with toileting along with bathing, dressing, and grooming. An unusual occurrence report dated 6/27/15, at 7:30 a.m. indicated C1 was being transferred off the toilet and the EZ stand device broke. C1 received a skin tear 1 centimeter (cm) by 2 cm to the top of her right hand and a bruise to the left	0 325		

Minnesota Department of Health

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0 325	Continued From page 2 forearm 3 cm by 8 cm. An unusual occurrence report dated 6/27/15, at 8:15 p.m. indicated C1 received a skin tear on the left forearm 8 cm by 3.5 cm. when the second strap was being applied to another EZ stand and it broke. The July 2015, medication administration record (MAR) revealed the skin tear on the right hand required a protective dressing which was checked daily and changed as needed. The skin tear on the left forearm was cleansed, triple antibiotic ointment (TAO) was applied along with a non-stick dressing and wrapped with gauze daily. The right hand was healed on 7/25/15. On 8/3/15, at 12:58 p.m. personal care attendant (PCA)-G stated on 6/27/15, she was working with PCA-H and they were going to raise C1 up from the toilet with the EZ stand. PCA-G stated PCA-H pushed the button on the EZ stand to raise it when the support that does the lifting broke and C1 dropped back down to the toilet. PCA-G stated she obtained another EZ stand from another unit to get C1 off the toilet. On 8/3/15, at 2:47 p.m. PCA-F stated she was going to get C1 ready to bring to the toilet while she was waiting for her co-worker to come to the room. PCA-F stated when she was about to attach the left strap of the sling to the EZ stand the machine broke. On 8/3/15, at 1:55 p.m. maintenance staff stated the actuator (the main mechanism that lifts the resident to a standing position) looked like it was worn through. He verified no preventative maintenance had been completed on the EZ stands. Maintenance staff stated new parts were replaced on the two broken EZ stands and a new EZ stand was purchased the day after the	0 325		

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0 325	Continued From page 3 incident. In addition, the maintenance staff stated the manufacturer's instructions for the new EZ stand identified a thorough safety checklist to be done monthly. On 8/4/15, at 10:08 a.m. the owner stated the actuator of both EZ stands had "busted." The owner stated when he received the manufacturer's instructions from the new EZ stand he found out the actuator should be checked monthly and lubricated. The owner stated he should have been checking the EZ stands more closely. On 8/5/15, at 3:39 p.m. the EZ Way service manager stated the top bolt and the actuator should have been greased on a monthly basis. He stated the safety checklists were available by mail or online. An EZ stand policy was requested and none was provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 325		
0 805	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 licensee failed to ensure that an allegation of maltreatment was reported to the common entry point as required in a timely manner for 1 of 2 client (C1) allegations reviewed. This practice	0 805		

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0 805	Continued From page 4	0 805		

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), and is issued at an isolated scope (1 or a limited number of clients are affected).

Findings include:

C1's medical record was reviewed. An unusual occurrence report dated 6/27/15, at 7:30 a.m. indicated C1 was being transferred off the toilet and the EZ stand device broke. C1 received a skin tear 1 centimeter (cm) by 2 cm to the top of her right hand and a bruise to the left forearm 3 cm by 8 cm. An unusual occurrence report dated 6/27/15, at 8:15 p.m. indicated C1 received a skin tear on the left forearm 8 cm by 3.5 cm. when the second strap was being applied to the EZ stand and it broke.

The licensee's internal investigative documents indicated the licensee did not report the allegation of possible maltreatment to the common entry point (CEP) until 6/29/15, (2 days later).

On 8/4/15, at 8:23 a.m. registered nurse (RN)-A nurse manager stated she was not aware of the incident over the weekend so she notified the state agency on Monday 6/29/15, when she became aware of the incident. RN-A stated the incident was to be reported within 24 hours. RN-A stated RN-B nurse manager was on-call over the weekend. RN-A stated she and RN-B talked about the incident Monday morning 6/29/15, and with input from the CEP determined it was a reportable incident.

The licensee's policy titled, "Vulnerable Adult (VA) Abuse Prohibition Plan" dated 1/09, indicated the following. The Vulnerable Adult Protection Act

Minnesota Department of Health

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0 805	Continued From page 5 requires mandated reporters to make an immediate report when there is reason to believe a VA is or has been maltreated, or they have knowledge that a VA has sustained a physical injury, which is not reasonably explained. Any employee should report any suspected or known cases of resident maltreatment to their immediate supervisor. The supervisor will immediately route the information to the administrator and nurse manager or their designees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 805		
02015	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 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).	02015		

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02015	Continued From page 6 (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. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that an allegation of maltreatment was reported to the common entry point as required in a timely manner for 1 of 2	02015		

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02015	Continued From page 7 client (C1) allegations reviewed. 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), and is issued at an isolated scope (1 or a limited number of clients are affected). Findings include: C1's medical record was reviewed. An unusual occurrence report dated 6/27/15, at 7:30 a.m. indicated C1 was being transferred off the toilet and the EZ stand device broke. C1 received a skin tear 1 centimeter (cm) by 2 cm to the top of her right hand and a bruise to the left forearm 3 cm by 8 cm. An unusual occurrence report dated 6/27/15, at 8:15 p.m. indicated C1 received a skin tear on the left forearm 8 cm by 3.5 cm. when the second strap was being applied to the EZ stand and it broke. The licensee's internal investigative documents indicated the licensee did not report the allegation of possible maltreatment to the common entry point (CEP) until 6/29/15, (2 days later). On 8/4/15, at 8:23 a.m. registered nurse (RN)-A nurse manager stated she was not aware of the incident over the weekend so she notified the CEP on Monday 6/29/15, when she became aware of the incident. RN-A stated the incident was to be reported within 24 hours. RN-A stated RN-B nurse manager was on-call over the weekend. RN-A stated she and RN-B talked about the incident Monday morning 6/29/15, and with input from the CEP determined it was a reportable incident. The licensee's policy titled, "Vulnerable Adult (VA) Abuse Prohibition Plan" dated 1/09, indicated the	02015		

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02015	Continued From page 8 following. The Vulnerable Adult Protection Act requires mandated reporters to make an immediate report when there is reason to believe a VA is or has been maltreated, or they have knowledge that a VA has sustained a physical injury, which is not reasonably explained. Any employee should report any suspected or known cases of resident maltreatment to their immediate supervisor. The supervisor will immediately route the information to the administrator and nurse manager or their designees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H26451	A. Building B. Wing	9/28/2015

Name of Facility	Street Address, City, State, Zip Code
VILLA COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

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 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 09/23/2015	ID Prefix 00805 Reg. # 144A.479, Subd. 6(a) LSC	Correction Completed 09/23/2015	ID Prefix 02015 Reg. # 626.557, Subd. 3 LSC	Correction Completed 09/23/2015
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	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/13/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO