MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
The Legacy of Delano
1350 St. Peter Avenue East
Delano, MN 55328
Wright County

Report #: HL26590006

Date: October 11, 2013

Date of Visit: March 21, 2013
Time of Visit: 9:00 a.m. – 3:00 p.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 neglect occurred when a client fell out of the lift when she was being put in the bathtub. The client hit her head causing a brain bleed.

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 indicates neglect occurred when staff did not apply safety straps to the tub chair and client. The client fell out of the chair and struck her head, sustaining a head bleed. The client died three weeks later.

The client had memory loss, confusion and was dependent on staff for all cares. The client's annual assessment indicated the client required physical assistance of two for bathing; however, the care plan indicated the client was to receive physical assistance of one person for bathing. The client was at risk for falls. The client leaned forwards or sideways while sitting. The home health aide took the client to the tub chair in her wheelchair and transferred her into the tub chair. The home health aide did not apply the chair's safety straps to secure the client in the tub chair. The home health aide wheeled the client and chair into the tub, and secured the chair in the tub. The home health aide bathed the client and then pulled the chair out of the tub to begin drying off the client. While the home health aide was drying the client, the client leaned forward and to the side in the chair. The client fell quickly before the home health aide was able to stop the fall. The client fell to the floor and struck her left side and left side of her head on the floor. The client bled from a head wound. The home health aide contacted the nurse who immediately called for emergency personnel. The client was transported to the hospital and diagnosed with a brain bleed. The client did not return to the assisted living facility but was transferred to a hospice facility where she died approximately three weeks after the fall. Review of the client's death certificate revealed the cause of death was complications of the injury the client sustained during the fall.

An interview with the home health aide revealed the client was bathed then wheeled out of the tub. The home health aide stated she squatted down in front of the client and chair to dry off the client. The client leaned forward and to the side, the chair moved an inch or two, and the client slipped out of the chair quickly before the staff was able to prevent the fall. The caregiver stated she was not trained to apply safety straps to clients in the tub chair. When staff were retrained after the incident, the home health aide found out that the straps were located in a cabinet in the tub room.

An interview was conducted with another home health aide who trained the home health aide who bathed the client on the day of the incident. She said that before this client's fall, staff did not use safety straps on the tub chair as they were not trained to use the safety straps. There were no safety straps on the tub chair. When she provided training about the tub, she focused on how the tub worked and not on the chair.

Staff interviews revealed inconsistent use of the safety straps for clients sitting in the tub chair.

The manufacturer instructions for use of the tub chair include the use of safety straps in the tub chair.

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 client's annual assessment and the care plan did not match related to the number of staff needed to bathe the client. The facility failed to provide consistent staff training and supervision of staff related to the bathing process and the use of safety belts on the tub chair.

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 Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

After the incident, the facility provided additional training to all staff regarding the tub, tub chair, use of straps and wheel brakes, and bathing protocols following the manufacturer guidelines.

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.

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

☒ 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: 4

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: no longer at the facility

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 8

Interview with staff: ◉ Yes ○ No ○ N/A Specify: 6 additional staff spoken with during the onsite facility tour and observations

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 3

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: safe patient handling	

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: tub room, tub, chair

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Nursing
Wright County Medical Examiners
Medina City Police Department
Wright County Attorney
Delano 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
	H26590	A. BUILDING: _____ B. WING _____	C 03/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST PETER AVENUE EAST DELANO, MN 55328

(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 #HL26590006. No correction orders are issued.	0 000		

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