This document has been re-scanned to the MDH website.

The compliance revisit was completed on 3/25/2015.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Lighthouse of Columbia Heights
3801 Hart Boulevard Northeast
Columbia Heights, Minnesota 55421
Anoka County

Report #: HL26853008

Date: December 8, 2014

Date of Visit: October 20, 2014
Time of Visit: 8:45 a.m. – 3:45 p.m.

By: Lisa Jacobsen, RN, 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 staff failed to provide adequate medical care when the client had a change in condition.

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:

The preponderance of evidence established that neglect of health care occurred when the facility failed to provide timely medical response to a client's change in condition. The client developed vomiting, diarrhea, abdominal pain, and abdominal distention and staff did not seek a timely medical evaluation. The client died with a cause of death being a bowel infarction (restricted blood supply to the bowel) due to an incarcerated hernia.

The client had a diagnosis of dementia and a history of an inguinal hernia. The client communicated her/his needs independently and required assistance with activities of daily living.

The client was diagnosed with a right inguinal hernia nine months prior to the client's death and received medical care twice for increased swelling and pain in the area of the hernia. Both times, the physician was able to reduce the hernia and gave instructions to return if unable to reduce the hernia and/or the client had unrelenting pain and swelling. In addition, the physician instructed staff to check for tenderness/pain in the client's inguinal hernia area when assisting the client to change her/his incontinent pad. This instruction was listed on the facility's electronic medication administration record although staff was not aware of this intervention and indicated they would not know it was listed there unless they were administering medications and looking to administer an as needed medication or treatment for the client.

The first change in the client's condition occurred on the evening shift, when the client was "irritable," and complained of her/his stomach hurting. On the overnight shift, the client had an emesis. None of these symptoms were reported to a nurse.

The following morning, staff observed the following regarding the client. The client complained of her/his stomach hurting when getting her/him up for the day. At approximately 7:15-7:30 a.m., the client, was screaming out "help me, help me" and pointed to her/his stomach. The client did not eat breakfast. The client vomited at least once. The client had several explosive bowel movements. The client complained of abdominal pain when staff barely touched the client's abdomen. The client's abdomen was "tight, distended" and/or "bloated." Staff was unable to button the client's pants because it was too tight and the client complained it hurt too much. After breakfast, the client's right side of her/his abdomen was "hard" and the client's right side of her/his abdomen appeared to look like a pregnant women with twins with an extremity poking out. The client repeatedly called out, "ow, ow" and was holding her/his abdomen. Staff stated these symptoms were reported to the nurse throughout the morning.

The client's family member noted the client could not talk because s/he was in so much pain, the client's

abdomen was distended and the client's skin color was white. The family member called 911 at 1:00 p.m. and the ambulance arrived at the facility at approximately 1:09 p.m.

Ambulance records indicated the client complained of right and left upper and lower quadrant pain/tenderness and rated her/his pain as ten out of ten on a pain scale, with ten being the worst pain.

Hospital records indicated the client was in shock and respiratory failure and was placed on a mechanical ventilator to assist with the client's breathing. Diagnostic tests were conducted and the client had a large strangulated right inguinal hernia with obstruction and necrosis (death of tissue) of the entire small bowel. An emergency surgical consult was conducted and it was determined that the client's disease was too extensive to conduct surgery. Comfort care was provided. The client was removed from the mechanical ventilator and died at 9:13 p.m. that evening.

The client's death certificate indicated the immediate cause of death was a "bowel infarction" due to or because of an incarcerated hernia.

The registered nurse (RN) stated she worked from approximately 8:00 a.m. to 9-9:30 a.m. on the day the client died. The RN stated the day shift staff reported the client had thrown up on the overnight shift. The RN stated she did not do a comprehensive examination of the client, but only listened to the client's lungs while the client was sitting at the breakfast table. The RN noted the client had some crackles in her/his lungs, but stated they were "not real bad that day." The RN stated she contacted the client's family to get the okay to do a chest x-ray and ordered a portable chest x-ray. The RN stated she was aware the client had an inguinal hernia, but stated the licensed practical nurses (LPN) "handled that."

The LPN stated he went to check on the client at approximately 8:30 a.m. and 11:15 a.m. the day the client died, and the client did not show any signs of distress at either visit. A document titled "Nursing Evaluation" completed by the LPN that morning indicated the following, "Writer was notified by caregivers that resident had a loose stool and one emesis. Writer went and assess resident but did not see the contents of the emesis because caregivers had thrown it away. Resident's lung sound had some crackles and bowel sounds was present in all quadrants. Resident not showing any signs of distress at time. Chest x-ray has been done and results pending." The LPN stated the client denied any pain. The LPN stated he did not palpate the client's abdomen, nor did the LPN notice the client's abdomen being distended. The LPN denied that staff reported that the client was having abdominal pain.

The client's physician indicated that despite the client's dementia, the client was able to verbalize if s/he had pain. The physician stated a person has approximately six hours once the herniated area is bulging or "stuck-out" before you have a risk of death of the bowel. The client's physician stated the symptoms a client would display when this happens were a bulge in the abdominal area that could not be pushed back in, nausea and vomiting and abdominal pain. The physician stated this is an emergency and if not treated can be fatal. The physician stated had the client gotten to the hospital sooner the client would have had a better outcome.

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. Although unlicensed staff were to check the client's inguinal hernia are during each incontinence pad change for swelling/tenderness, staff were not aware they were to do this. In addition, several unlicensed staff indicated they reported changes in the client's condition to a licensed nurse the day the client died, although the licensed nurse indicated staff did not report that the client was having abdominal pain. In addition, although the facility had a policy which indicated that staff were to report changes in client's condition immediately to a licensed nurse such as "vomiting" and "pain," the evening and the overnight shift before the client died, the client complained of stomach pain and vomiting and these symptoms were not reported to a nurse until the following morning. The cumulative effect of these omissions represent a system failure on the facility's part to monitor and report changes in a client's condition promptly.

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 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 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.

(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.

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: _____

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 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: The client was deceased.

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: 0

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 14

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator 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: _____	

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: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Columbia Heights City Police Department
Anoka County Attorney
Columbia Heights City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26853	A. BUILDING: _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE OF COLUMBIA HEIGHTS	3801 HART BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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 case #HL26853008. The following correction orders are issued. At the time of the investigation, there were 76 clients receiving services under their comprehensive license. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970. RECEIVED DEC 26 2014 OHFC	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 Home Care Providers. 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. 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/RULES.	
0 265	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to	0 265		

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0 265	Continued From page 1 accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that care and services were provided according to accepted nursing standards related to a timely medical evaluation for one of four clients (C1) reviewed who had a change in their condition. This practice resulted in a level 4 violation (a violation that results in serious injury, impairment, or death), and is issued at an isolated scope (1 or a limited number of clients are affected). The findings included: C1's record was reviewed. C1 had diagnoses of dementia and an inguinal hernia. C1's assessment dated September 3, 2014 indicated the client required regular prompting due to confusion and disorientation and required assistance with his activities of daily living. C1's individualized service plan dated September 3, 2014 indicated the client communicated independently. C1's progress note dated March 27, 2014 indicated the client's right testicle was extremely swollen and the client was taken to the doctor for evaluation. Discharge instructions from the physician indicated the client had an inguinal hernia and that staff were to "Evaluate right scrotum with each depends change. If he has tenderness have him evaluated immediately." C1's record also indicated the client was seen by a physician on April 19, 2014 for the same concerns.	0 265		

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0 265	Continued From page 2 C1's electronic medication administration record (MAR) for September 2014 indicated "Evaluate right scrotum with each depends change. If he has any tenderness or pain in the scrotum/groin area he needs to be evaluated immediately and notify a nurse." This was listed on the MAR as "as needed." When interviewed October 27, and October 31 at 11:03 a.m., 1:40 a.m. and 3:05 a.m. respectively, ULP-I, ULP-J and ULP-K were questioned regarding their awareness of the instruction to evaluate C1's right scrotum/groin area with each depends change. ULP-I, ULP-J and ULP-K stated they had never seen this instruction on the electronic MAR and had never been instructed by the nurses to monitor this. ULP-I stated when a instruction is listed "as needed" on the MAR, only staff passing medications would be able to see it and then they would have to be looking for a PRN (pro ra nata or as needed) medication for a client to be able to see the instruction. A "Shift Log Form" dated September 12, 2014 for the overnight shift of September 11, 2014 into the morning of September 12, 2014 indicated the following regarding C1, "Throw up on bed and cover; bed cover, clothes in washer." A progress note dated September 12, 2014 at 8:45 a.m., signed by registered nurse (RN)-A indicated that she completed rounds at 8:30 a.m. and spoke with caregivers who stated that C1 had one episode of vomiting phlegm. RN-A listened to the client's lungs and noted faint crackles in lower lungs. RN-A contacted daughter to ask if a chest x-ray could be done to rule out a chest infection. RN-A ordered a portable chest x-ray be done as soon as possible.	0 265		

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0 265	Continued From page 3 A "Nursing Evaluation " form dated September 12, 2014 (no time on the form) signed by licensed practical nurse (LPN)-L indicated the following, C1 has hernia at his groin area, vitals signs, temperature 97.4, pulse 82, respirations 20, blood pressure 126/80, oxygen saturation on room air was 92%. The note indicated LPN-L checked C1's vitals, lung sounds, heart sounds and bowel sounds. Heart sounds were regular, lung sounds had some crackles, bowel sounds present in all four quadrants and under the section pain, the area was left blank. Additional notes indicated that the writer was notified by caregivers that the client had a loose stool and one emesis. The client's lung sounds had some crackles and bowel sounds were present in all quadrants. "Resident not showing any signs of distress at this time." Chest x-ray has been done and results pending. A progress note dated September 12, 2014 at 10:30 a.m. indicated that writer received report from LPN-L that resident was being transferred by ambulance per request of a family member. An ambulance report indicated the ambulance was dispatched at 1:00 p.m. on September 12, 2014 and arrived at the facility at 1:09 p.m. The ambulance report indicated C1 complained of pain/tenderness in his right and left upper and lower quadrants, which the client described the abdominal pain as 10/10, on a pain scale with 10 being the worst pain ever. Hospital records indicated the following, the physical examination indicated C1's blood pressure was 96/64 with a pulse of 154 and respirations 18. C1's gastrointestinal exam indicated, "distended tympanic Large right	0 265		

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0 265	Continued From page 4 inguinal hernia. Imaging results were obtained and C1 had a strangulated right inguinal hernia with obstruction and necrosis of the entire small bowel proximal to the strangulation. A surgical consult was obtained and it was decided that C1 was not a surgical candidate and as the disease was too extensive. C1 passed away at 9:13 p.m. on September 12, 2014 at the hospital. C1's Death Certificate indicated the cause of death was a "Bowel infarction due to an incarcerated hernia." When interviewed October 22, 2014 at 11:35 a.m., unlicensed staff person (ULP)-E stated she worked the afternoon shift on September 11, 2014. ULP-E stated she took C1 to the bathroom between 2:00-3:00 p.m. and C1 complained that his suspenders were too tight. ULP-E stated she adjusted C1's suspenders. When interviewed October 22, 2014 at 9:15 a.m., ULP-C stated she worked the afternoon shift on September 11, 2014. ULP-C stated the only thing different that she noticed about C1 on her shift is that C1 complained about his stomach hurting, which was unusual for him. ULP-C stated she reported this to the person passing medications. When interviewed October 24, 2014 at 7:45 a.m., ULP-N stated she worked the overnight shift of September 11, 2014 into the morning of September 12, 2014. ULP-N stated that C1 reported that his bedspread was wet and that he had thrown up on it. ULP-N stated there was a small stain on the bedspread. When interviewed October 27, 2014 at 3:05 p.m., ULP-J stated she arrived at work at approximately 6:15 a.m. on September 12, 2014.	0 265		

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0 265	Continued From page 5 ULP-J stated she had noted in the log book that C1 had thrown up on the overnight shift. ULP-J went into C1's room and found several 4-5 ounce drinking cups in C1's bathroom that had a heavy mucous in them. ULP-J assisted the client to get dressed and brought the client to the dining room. At approximately 7:15-7:30 a.m., C1 was screaming "help me, help me". When questioned what was wrong, C1 pointed to his stomach. C1 did not eat any breakfast which was very unusual for him. C1 went to his bedroom. Approximately five minutes later staff went to check on the client and the C1 had been incontinent of bowel movement all over the floor. ULP-J stated she contacted LPN-L, who came to check on the client and stated he would contact the doctor and family member to get an x-ray of C1's chest because of coughing. At approximately 9:00 a.m., C1 complained of his stomach hurting again and his skin color was yellowish and he had another bowel movement in a garbage can. ULP-J contacted LPN-L again because of C1's skin color change ULP-J stated LPN-L came to see C1 again and stated he had ordered an x-ray and was going to call the family member. ULP-J stated she went on break and when she came back, C1's skin color had turned to white. C1's daughter was present and called 911. When interviewed October 22, 2014 at 10:15 a.m., ULP-D stated he worked the day shift on September 12, 2014. ULP-D stated when assisting C1 to get dressed, C1 complained of not feeling well and that his stomach hurt. ULP-D stated he noticed C1's stomach was distended. ULP-D stated C1's abdomen looked like it was bloated and tight. C1's pants didn't fit and when he tried to button them C1 said it hurt too much so C1's pants were left unbuttoned. ULP-D asked	0 265		

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0 265	Continued From page 6 the caregivers if they reported this to the nurse and they said yes. When interviewed October 23, 2014 at 11:00 a.m., ULP--F stated she worked September 12, 2014 on the day shift and was passing medications. ULP-F stated C1 was sitting at the dining room table and said he was in pain. ULP-F questioned C1 about the pain, and C1 stated his stomach hurt. ULP-F stated she touched C1's abdomen and stated it felt bloated and tight. ULP-F stated C1's abdomen was larger than normal also. ULP-F stated she asked C1 if he needed to use the bathroom which C1 responded yes. ULP-F gave C1 some milk of magnesia. ULP-F stated staff reported to her that C1 had two bowel movements after giving the milk of magnesia. When interviewed October 31, 2014 at 2:50 p.m., ULP-O stated she worked the day shift on September 12, 2014. ULP-O stated C1 was observed holding his abdomen and calling out loudly "ow, ow, ow." ULP-O stated C1 was also very restless would lie down and then get up and then lie down again. When interviewed October 31, 2014 at 12:40 p.m., ULP-K stated she worked the day shift on September 12, 2014. ULP-K stated shortly after breakfast, ULP-K noticed that C1 had not gotten up from the breakfast table, so she assisted him. C1 complained that his pants were too tight, and called out "ow, ow, ow." ULP-K assisted C1 to his room to change his pants. ULP-K stated she noticed the right side of C1's abdomen was distended and hard. ULP-K described C1's abdomen "like a pregnant women with twins with an extremity poking out." ULP-K stated she gently touched C1's abdomen and C1 said "ow,	0 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26853	A. BUILDING: _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE OF COLUMBIA HEIGHTS	3801 HART BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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0 265	Continued From page 7 ow." ULP-K stated she couldn't button or zip C1's pants because C1's abdomen was swollen. ULP-K stated she put a t-shirt on C1 and his suspenders. ULP-K stated someone was going to tell the nurse (unsure who) as her shift was ending. When interviewed October 23, 2014 at 3:15 p.m., ULP-G stated she worked the day shift on September 12, 2014. ULP-G stated when assisting C1 with morning cares, she noted a cup with emesis in it on C1's bathroom sink. C1 stated C1 stated he could not eat breakfast as he felt he would throw it back up if he ate. ULP-G stated she barely touched C1's abdomen and C1 said "ow, ow, ow." ULP-G stated C1 vomited one time that she witnessed and had two-three loose stools. ULP-G stated she notified the nurse and when the nurse checked on C1, the nurse listened to C1's bowels and said they were moving. When interviewed October 23, 2014 at 12:20 p.m., RN-A stated she worked September 12, 2014 from approximately 8:00 a.m. until 9:00-9:30 a.m. RN-A stated she saw C1 sometime before 9:00 a.m. that morning. RN-A stated she did not do a comprehensive examination, but rather just listened to C1's lungs when the client was sitting at the breakfast table. RN-A stated she noted C1 had some crackles in his lungs, but "not real bad that day." A staff person reported that C1 had thrown up on the overnight shift. RN-A stated she contacted C1's daughter to do a chest x-ray. RN-A stated she ordered the chest x-ray and documented in C1's chart. When interviewed November 7, 2014 at 10:00 a.m., LPN-L stated he worked day shift September 12, 2014. LPN-L stated he went to	0 265		

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0 265	Continued From page 8 see C1 around 9:30-10:00 a.m. and stated C1 was showing no signs of distress. When questioned regarding the "Nursing Evaluation" form that was completed and the area of "pain" was left blank, LPN-L stated he asked C1 if he had pain, but with dementia patients, C1 said he had no pain. LPN-L stated he was not the only one that assessed C1, that his charge nurse, RN-A also went to see C1. When questioned if when he placed his stethoscope on C1's abdomen if C1 complained of pain, LPN-L stated he did not palpate C1's abdomen and no C1 did not complain of pain. LPN-L denied noting that C1's abdomen was distended. LPN-L stated staff did not report that C1 was screaming/calling out in pain. LPN-L stated he saw C1 again around 11:15 a.m. and C1 was not showing any signs of distress. LPN-L stated he did not recall doing any physical assessment of the client around 11:15 a.m. and he thought he told the caregivers to do a set of vital signs. When interviewed December 1, 2014 at 1:05 p.m., Physician P indicated that despite the client's dementia, the client was able to verbalize if he had pain. The physician explained that a person had approximately six hours once the herniated area was bulging or "stuck-out" before there was a risk of death of the bowel. The client's physician stated the symptoms a client would display when this happened were a bulge in the abdominal area that could not be pushed back in, nausea and vomiting and abdominal pain. The physician stated this was an emergency situation and if not treated could be fatal. The physician stated had C1 gotten to the hospital sooner the client would have had a better outcome. The facility's policy titled, "Resident Change in	0 265		

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0 265	Continued From page 9 Condition Policy dated September 2, 2014 indicated the following, "All team members must communicate any change in the resident condition to a licensed nurse. The nurse will then take the appropriate action, including notifications as required." The policy further indicated that when a resident demonstrated a change of condition, the team member observing the change will communicate the change to a licensed nurse immediately. The communication may occur in person or by telephone. Two of the changes in condition that were listed as needing to be communicated to the nurse immediately were, vomiting and new onset of pain. TIME PERIOD FOR CORRECTION: Seven (7) days	0 265		
0 320	144A.44, Subd. 1(13) Treated With Respect Subdivision 1. Statement of rights. A person who receives home care services has these rights: (13) the right to be treated with courtesy and respect, and to have the client's property treated with respect; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that clients were treated with courtesy and respect for one of one client reviewed. The 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 a isolated scope (1 or a limited number of clients are affected). The findings included:	0 320		

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0 320	Continued From page 10 When interviewed October 17, 2014 at 9:35 a.m., Family member M indicated that on September 5, 2014 at 2:30 a.m., C1 contacted Family Member-M by telephone and complained that he had a cough and that they were not giving him his cough medicine. While on the telephone, Family Member-M heard someone in the background screaming, "(clients name) you put that phone down now. (client's name) you put that phone down immediately, right now. What are you doing? You get back to bed now! " Family Member-M heard rustling of the phone. Family Member M yelled loudly "Hello." A female voice came on the phone and said "Who is this?" Family member -M identified herself and indicated that C1 could call anytime day or night whenever he wanted. The female on the phone stated she was worried C1 would wake up his wife who shared the apartment and bed with C1. Family Member -M asked the female if she did not think she would wake up his wife with her loud screaming. The female said nothing. Family member-M asked the name of the staff person. The staff person was unlicensed staff person (ULP)-N. Family member-M stated she reassured C1 that it was okay to call her anytime of the day. C1 stated he was afraid of ULP-N. The facility's internal investigation dated September 6, 2014 indicated ULP-N was questioned regarding the incident. ULP-N denied "yelling" but indicated she asked C1 about the phone. The plan was to move ULP-N schedule to not work on the floor C1 resided "until further notice." The Resident Services Record indicated ULP-N provided services for C1 on the overnight shifts of September 9, 10 and 11, 2014, even after the plan was not not have ULP-N work on the floor	0 320		

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0 320	Continued From page 11 C1 resided. The facility's policy on treating clients with dignity and respect is titled, "Home Care Bill of Rights" dated August 29, 2014. The policy states, "All our staff receive training about the bill of rights and are expected to adhere to these rights." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 320		
0 715	144A.476, Subd. 2 Employees, Contractors, and Volunteers Subd. 2. Employees, contractors, and volunteers. (a) Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information. (b) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not subject the home care provider to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that background studies were completed for one of seven employees (A) reviewed. This practice resulted in a level 2	0 715		

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0 715	Continued From page 12 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 a isolated scope (1 or a limited number of clients are affected). The findings included: Registered nurse (RN)-A's personnel file was reviewed. RN-A was hired to work for the home care provider on February 17, 2014 and provide nursing services. There was no background study from the Minnesota Department of Human Services in employee's file. A correspondence received from the director of operations on October 21, 2014 revealed a background study was submitted by a supplemental staff agency on January 17, 2014 for RN-A. On October 21, 2014 at 9:08 a.m., the investigator checked with the background study unit as to whether a background study had been submitted by the home care provider for RN-A. No background study had been submitted by the home care provider for RN-A. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 715		

AH Form Approved
3/25/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H26853	A. Building B. Wing	2/26/2015

Name of Facility	Street Address, City, State, Zip Code
LIGHTHOUSE OF COLUMBIA HEIGHTS	3801 HART BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

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 00320 Reg. # 144A.44, Subd. 1(13) LSC	Correction Completed 02/26/2015	ID Prefix 00715 Reg. # 144A.476, Subd. 2 LSC	Correction Completed 02/26/2015	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By: MDH State Agency	Reviewed By AS:PB	Date: 03/25/2015	Signature of Surveyor: 30157	Date: 02/26/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/25/2014

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