Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL270145165M
Compliance #: HL270148880C

Date Concluded: September 19, 2023

Name, Address, and County of Licensee Investigated:
Anika Home Care
6603 Queen Avenue South, Suite F
Richfield, MN 55423
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected a client when they failed to provide appropriate care and services per the service plan, when the facility allowed unlicensed staff to work continuous 72 hour shifts and failed to have a registered nurse train the staff.

Also, the Alleged Perpetrator (AP1) neglected to provide requested cardiopulmonary resuscitation (CPR) when the client became unresponsive, and the client died.

In addition, AP2 and AP3 neglected the client when they were disrespectful, were frequently late, and refused to transport the client to appointments.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the neglect when they failed to ensure they had enough skilled nurses to care for the client 24 hours per day, per the service agreement. The facility allowed unlicensed

personnel to work continuous 72-hour shifts with no plan for sleep, failed to ensure a registered nurse provided training to unlicensed staff, and failed to have a registered nurse available for consultation for unlicensed staff. A staff member who was working a scheduled 72-hour shift fell asleep, and woke to find the client, who had a tracheostomy and depended on a ventilator, not breathing. The client died.

The allegation regarding implementation of CPR was inconclusive due to conflicting information. The family, who were onsite at the time of the incident, reported the AP did not immediately start CPR and appeared to not know how to do CPR with a trach dependent client. A law enforcement report indicated officers observed the AP doing CPR when they arrived three minutes after being dispatched to the home. Emergency medical technicians arrived shortly after and despite continued lifesaving efforts the resident passed away.

The allegation regarding AP2 and AP3 being disrespectful, late, and refusing to transport the client were inconclusive due to lack of information provided.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members, law enforcement, and the medical examiner's office. The investigation included review of law enforcement reports, medical examiner's report, and medical records. The facility failed to provide requested documents.

The client received comprehensive home care services in their home. The resident's diagnoses included chronic respiratory failure with tracheostomy in place, ventilator dependence, and obesity. The client's service plan included skilled nursing care for suction, cares, and changes to her tracheostomy. The service plan indicated the client required assistance with bathing dressing, hygiene, toileting, incontinence cares, and transfers with a full mechanical lift.

A law enforcement report indicated a family member called 911 because the client had stopped breathing. On the 911 call, the operator was heard instructing the family to have someone begin CPR. A family member was heard stating there was a nurse there (referring to the AP who was not a licensed nurse) but could not understand why the AP did not start CPR.

During an interview, a family member stated the facility did not have enough trained nursing staff to provide twenty-four-hour care for the resident. The family member stated they were not aware some of staff caring for the resident were unlicensed and were horrified that the unlicensed staff caring for the client on the day of her death had no training in CPR.

During investigative interviews, multiple unlicensed staff members stated they worked continuous two-to-three-day shifts, trying to find time to sleep when the client slept. The staff stated their job was to ensure equipment was plugged in, provided the client with grooming, transfers, and housekeeping. The staff stated if the client became ill, they were directed to call 911.

During an interview, AP1 stated an administrative staff (who was a licensed practical nurse (LPN)), provided his training. The AP stated he was not a licensed nurse, did not receive CPR training, but the administrative staff showed him how to “push air into” the resident with a bag to her stoma.

During an interview, the administrative staff stated he provided training and verified they had no registered nurse to provide training or for consultation.

In conclusion neglect is substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
White Bear Lake City Attorney
White Bear Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27014	A. BUILDING: _____ B. WING _____	C 09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIKA HOME CARE	6603 QUEEN AVE S, STE F RICHFIELD, MN 55423

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482 these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL270148880C/#HL270145165M On September 5, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there was 1 client receiving services under the provider's Comprehensive license. The following correction orders are issued for #HL270148880C/#HL270145165M tag identification 0265, 0325, 0545, and 0715.	0 000	Minnesota Department of Health is documenting the State 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 evaluators' 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).	
0 265 SS=J	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice	0 265		

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0 265	Continued From page 1 receive care and services according to a suitable and up-to-date plan, and subject to 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 provide adequate care and services for 24-hour skilled nursing care for one of one client (C1) reviewed for maltreatment. The licensee did not ensure a registered nurse provided training to unlicensed personnel and failed to have a registered nurse available for consultation. Unlicensed personnel (ULP)-F worked a scheduled 72-hour shift, fell asleep, and woke to find C1, who had a tracheostomy and depended on a ventilator, not breathing. The licensee failed to train or ensure ULP-F was trained in cardiopulmonary resuscitation (CPR). C1 died. 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 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings included: C1's record was reviewed. C1 began receiving home care services from the licensee on April 14, 2022. C1's diagnoses included chronic respiratory failure, ventilator dependence, chronic kidney disease, and obesity. C1's Service Contract/Agreement document	0 265	Minnesota Department of Health is documenting the State 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 evaluators' 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	

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0 265	Continued From page 2 dated March 24, 2022, indicated the licensee would provide registered nurse (RN) services to C1, 24 hours per day, seven days per week. C1's MN Choices Support Plan document dated April 14, 2022, indicated the licensee provided "Home care nursing-RN Complex". The document indicated C1 required nursing care to suction, care for and change her tracheostomy, as well as provide medication management, transfers with a full mechanical lift, and continuous care to ensure health and safety. During an interview on September 6, 2023, at 10:00 a.m. family member (FM)-A stated she was present at C1's home on the day of C1's death. FM-A stated she was outside with another family member when ULP-F ran out yelling "[C1]'s not breathing!" FM-A went into the house and observed ULP-F running in and out of the house making phone calls and trying to move his car instead of initiating CPR. FM-A stated ULP-F tried to give C1 respirations by mouth to mouth but C1's tracheostomy cuff was inflated, so no air went through. FM-A stated the licensee never had enough nurses to care for C1, but due to C1's mental health behaviors they had no other options for care. FM-A stated the licensee assigned "nurses" three days in a row (72-hour shifts) and FM-A had no idea when or how the "nurses" slept. FM-A stated awareness of a situation where a "nurse" worked nine days in a row (216 hours). FM-A stated she questioned whether all staff working with C1 were nurses. During an interview on September 12, 2023, at 11:00 a.m., director (D)-B stated he initially scheduled staff to work 12 hour shifts with C1, but "they [staff] adjusted the schedule themselves." D-B stated policy did not allow for staff to sleep	0 265	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	

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0 265	Continued From page 3 when providing cares, "but if they did, it was when family members were there to care for" C1. D-B acknowledged some staff worked three days in a row (72 hours). D-B stated he held a license as a practical nurse (LPN) and provided all the training and did not identify a registered nurse (or Clinical Director as noted in the registered nurse job description) responsible for consultation or training. D-B stated he did not do an investigation of C1's incident but talked with ULP-F. D-B stated ULP-F told him he did CPR until the ambulance arrived. During an interview on September 12, 2023, at 12:00 p.m., FM-C stated she observed ULP-F sleeping in the hour prior to the incident and took a picture of him. FM-C stated she was outside when ULP-F came out to say C1 was not breathing. FM-C stated she saw ULP-F running around while FM-C was on the phone with the 911 operator. FM-C stated ULP-F would not start CPR and appeared to not know how to do CPR. During an interview on September 12, 2023, at 3:53 p.m., unlicensed personnel (ULP)-D stated the licensee did not have enough staff to work with C1, so the staff put together a schedule to work three days in a row. ULP-D stated the staff role was to ensure C1's ventilator was plugged in, and to call 911 if C1 was "not feeling well". ULP-D stated the staff would try to sleep when C1 slept, but she often stayed up asking for things all night. ULP-D stated D-B provided all their training. During an interview on September 13, 2023, at 9:00 a.m. ULP-E stated the cares for C1 included changing her linens, assisting with bathing, toileting, incontinence cares, and transfers with a full mechanical lift. ULP-E stated C1 had a	0 265		

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0 265	Continued From page 4 catheter, but ULP-E did not have to change it or measure output. ULP-E stated she and ULP-D were the only ones who wanted to work with C1, so they told the licensee they made a schedule to work three days in a row. ULP-E stated she would sometimes sleep when C1 slept. ULP-E stated she received some training from a registered nurse, but that nurse quit two years ago, so D-B completed all the training since then. During an interview on September 13, 2023, at 12:26 p.m., ULP-F stated he received training from D-B on how to do vital signs, document, and how to give medication. ULP-F stated he received training at C1's home from ULP-D. ULP-F stated he did not receive training on how to perform CPR, but D-B once showed him how to connect the oxygen bag onto C1's stoma and "push air into her". ULP-F stated on the day of C1's death he had taken C1's vital signs around 3 pm and they "were fine" so he tried to get some rest while C1 was sleeping. ULP-F stated when he woke up, C1's vent machine was beeping as normal, but he noticed she was not breathing and was blue. ULP-F stated he did the best he could, family called 911, and he tried to do CPR until the paramedics came. During the 911 recording from February 5, 2023, (provided by FM-A), the operator was heard repeatedly telling the caller (a family member) to start CPR. The family member stated, "We have a nurse in the house. [ULP-F] they want you to start CPR! You can't leave to make a phone call! Good God he's a nurse and he's running out to make a phone call! I don't know if he knows what he's doing." On September 5, 2023, at 4:43 p.m., September 6, 2023, at 2:02 p.m., September 13, 2023, at	0 265		

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0 265	Continued From page 5 2:40 p.m., and September 15, 2023, at 2:56 p.m. the MDH investigator requested additional C1 medical record documentation, personnel records, and policies, but the licensee did not provide them. TIME PERIOD FOR CORRECTION: Two (2) Days.	0 265		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment 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: The facility failed to ensure one of one clients reviewed (C1) was free from maltreatment.. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	0 325		
0 545 SS=F	144A.474, Subd. 5 Information Provided by Provider The home care provider shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.	0 545		

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0 545	Continued From page 6 This LEVEL A is not met as evidenced by: Based on interview and document review, the licensee failed to provide accurate and truthful information during a complaint investigation. This had the potential to affect all clients, employees, and potential clients. This practice resulted in a level two 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.) Findings include: During a desk complaint investigation on September 5, 2023, at 4:30 p.m. the Minnesota Department of Health (MDH) investigator called the office number for the licensee and received no answer after 25 rings, and no option to leave a message. The MDH investigator called the afterhours number for the licensee with no answer and no option to leave a message. On September 5, 2023, at 4:43 p.m. the MDH investigator sent an e-mail to director (D)-B and the company with a request for documents, including the following: 1) Schedule of staff who cared for client (C-1) in January 2023, and February 2023. 2) List of staff with contact information. (Including staff who cared for C1 but were no longer employed.) 3) Policies- Vulnerable Adult/Reporting Maltreatment, Service Plans, Job description for	0 545		

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0 545	Continued From page 7 RN and LPNs. 4) All incident reports regarding C1 for dates October 1, 2022, through February 5, 2023. 5) All grievances filed by/for C1 from October 1, 2022, through February 5, 2023. 6) C1's medical record: Face sheet, Service Plan, Care plan, Individual Abuse Prevention Plan, Medication Administration Record for January and February 2023, Progress notes for October 1, 2022, through February 5, 2023. 7) Personnel file for unlicensed personnel (ULP)-E: Demographic information (full name, date of birth, phone number, mailing and email address), training records, performance evaluations, write-ups/coaching meetings. On September 6, 2023, at 10:16 a.m., D-B sent an e-mail to the MDH investigator indicating he was on vacation out of state, would not return for four more days, and would provide the documents requested. On September 6, 2023, at 10:53 a.m., the MDH investigator sent an e-mail to D-B inquiring if he still owned the home care business, provided home care for clients, and if he had another person who could send the documents and received no response back. On September 6, 2023, at 2:02 p.m., the MDH investigator sent an e-mail to D-B with a request to send the documents by 12:00 p.m. on Monday September 11, 2023. On September 11, 2023, at 11:23 a.m., the MDH investigator received a 46-page fax from D-B, which failed to include the following requested documents: 1) Schedule of staff who cared for client (C-1) in January 2023, and February 2023.	0 545		

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0 545	Continued From page 8 2) List of staff with contact information. (Including staff who cared for C1 but were no longer employed.) 3) Policies- Vulnerable Adult/Reporting Maltreatment, Service Plans, Documentation. 4) All incident reports regarding C1 for dates October 1, 2022, through February 5, 2023. 5) All grievances filed by/for C1 from October 1, 2022, through February 5, 2023. 6) C1's Service Plan, Individual Abuse Prevention Plan, Medication Administration Record for January and February 2023, Progress notes for October 1, 2022, through February 5, 2023. 7) Personnel file for unlicensed personnel (ULP)-E: Demographic information (full name, date of birth, phone number, email address), training records, performance evaluations, write-ups/coaching meetings. On September 11, 2023, at 12:05 p.m., the MDH investigator received an e-mail from D-B that indicated "the nursing book was at [R1's] house, the police who responded to the 911 call took it from us, it contain [sic] most of the documents that you were asking for." During an interview on September 12, 2023, at 11:00 a.m., D-B stated the staffing schedule for C1 included 12-hour shifts initially, but the staff "adjusted it" and worked up to 24-hour shifts. D-B stated he was aware staff worked three day shifts as well. D-B stated the policy indicated staff would not sleep while caring for C1, but if they did, it would be when C1's personal care attendant (PCA) or family member was present. D-B stated he did not have a copy of C1's staff schedule. D-B stated the staff had a list of tasks to perform for C1, but he did not have a copy of the documentation. D-B stated the police took C1's "book" from her home, which contained all	0 545		

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0 545	Continued From page 9 her documentation, such as nursing assessments, medication administration records, and progress notes for their investigation into C1's death. D-B stated he had no additional documents for C1. D-B stated he usually would have staff bring some of the resident record into the office but had not for C1. On September 13, 2023, at 2:40 p.m. the MDH investigator requested background study documentation for ULP-D, ULP-E, and ULP-F, as well as the following policies: Background studies, Staffing, Availability of a Registered Nurse, Supervision of Unlicensed Personnel, and Record Retention. On September 15, 2023, at 2:56 p.m. the MDH investigator e-mailed D-B with a request to send the documents by 9:00 a.m. on Monday September 18, 2023. The MDH investigator did not receive requested documents from D-B. TIME PERIOD FOR CORRECTION: Two (2) Days.	0 545		
0 715 SS=F	144A.476, 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	0 715		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27014	A. BUILDING: _____ B. WING _____	C 09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANIKA HOME CARE	6603 QUEEN AVE S, STE F RICHFIELD, MN 55423

(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
0 715	Continued From page 10 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 conduct background studies for three of three unlicensed personnel (ULP-D, ULP-E, and ULP-F) who provided direct care and services for C1. This had the potential to impact all clients of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: A review of Minnesota Department of Human Service background study website (https://netstudy2.dhs.state.mn.us/Live/Home) on September 5, 2023, at 1:28 p.m. revealed the licensee roster (HFID#27014) did not include background studies requested for ULP-D, ULP-E, and ULP-F. During an interview on September 12, 2023, at 3:53 p.m., ULP-D verified she provided direct care and services for C1. During an interview on September 13, 2023, at 9:00 a.m., ULP-E verified that she provided direct	0 715		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 715	Continued From page 11 care and services for C1. During an interview on September 13, 2023, at 12:26 p.m., ULP-F verified that he provided direct care and services for C1. The MDH investigator emailed director-(D)-B on Wednesday September 13, 2023, at 2:240 a.m. and Friday September 15, 2023, at 9:56 a.m. requesting personnel records (including background studies) for ULP-D, ULP-E, and ULP-F, but the licensee failed to send personnel documents or policies related to background studies. TIME PERIOD FOR CORRECTION: Two (2) Days	0 715		