Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL27108024M
Compliance #: HL27108025C

Date Concluded: January 13, 2020

Name, Address, and County of Licensee Investigated:
Ebenezer Home Care
2722 Park Avenue South
Minneapolis, MN 55407
Hennepin County

Name, Address, and County of Housing with Services location:
Shorewood Landing
6000 Chaska Road
Shorewood, MN 55331
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Casey DeVries, RN
Special Investigator

Finding: Substantiated, individual 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.

Allegation(s):
It is alleged: It was alleged that a client was neglected when the alleged perpetrator (AP) failed to answer the client's call light and perform scheduled services, which contributed to the client's fall. Staff found the client on the floor with his left arm pinned near the spokes of the wheelchair. The client's arm was without a pulse for an unknown period.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP was responsible for the maltreatment. The AP, whom the facility had assigned to care for the client, failed to assist the client with scheduled toileting, repositioning and safety checks, and did not answer the client's call light for 148 minutes. Additionally, despite awareness that the client's family member had called the facility to request care for the client during that period of time, the AP did not assist the client.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigator observed the facility's day-to-day operation on the memory care unit. The

investigation included review of client medical records, incident reports, internal investigation notes, call light response records, facility policies and procedures, grievances, scheduling records, personnel records, and staff meeting records.

The client's service agreement indicated the client received assistance from staff for all activities of daily living for diagnoses that affected the client's cognition and mobility. The client had services scheduled every one hour due to a history of anxiety and forgetfulness related to cares. The client used a pendant to call staff, and the client would regularly phone his spouse who would in turn phone staff to alert them if the client had a care need.

Review of a facility incident report indicated the client fell in his bedroom while attempting to self-transfer and that staff found him on the floor with his arm stuck in the wheel of his wheelchair. The incident report indicated staff called 911 and that emergency medical services (EMS) transported the client to the hospital.

Facility management conducted an internal investigation, which included review of surveillance camera footage, review of the client's pendant call record, and interviews of the staff who worked at the time of the incident. The internal investigation indicated review of the camera footage showed the following:

- The AP brought the client back to his room following dinner at 4:54 p.m.
- The AP used his personal phone while sitting on a sofa in the common area from 5:44 p.m. to 6:04 p.m.
- The AP sat in a booth in the common area from 6:05 p.m. to 6:17 p.m., during which time, the AP removed his shoes, put on sandals and was looking at his phone.
- The AP did not return to the client's room until 7:10 p.m.

The client's service delivery record indicated the client had toileting assistance and a safety check scheduled for 6:00 p.m., as well as toileting, a safety check and repositioning at 7:00 p.m. The AP documented he completed the client's 6:00 p.m. services.

The internal investigation notes revealed that the client's pendant was active from 4:56 p.m. to 7:24 p.m., and that the client's spouse had called the facility to alert the caregiver that the client needed assistance to use the bathroom at 5:43 p.m. While another caregiver received the spouse's call to the facility, video footage corroborated the caregiver's statement to management that she immediately informed the AP about the spouse's call. The caregiver was in the same area as the AP at the time of the call, and the video footage revealed the caregiver spoke to the AP after the call ended. Facility management determined through internal investigation that the AP failed to provide the client with the spouse's request for care at 5:43 p.m. or with the scheduled cares at 6:00 p.m.

Review of a police report indicated a police officer observed upon entry to the client's room that the client was halfway out of his wheelchair and that the client's left arm was stuck behind his back in between the spokes of the wheelchair. The police officer documented that he and fire

department personnel worked to free the client's arm from the wheelchair. The police officer performed an assessment on the client, and documented that the client's arm was cold, pale, and that the officer had difficulty locating a radial (wrist) pulse. The police officer documented after a few moments that circulation returned to the client's arm, the color improved, and he was able to locate a strong radial pulse.

Review of the client's hospital record indicated, "[the client's] arm was wrapped behind him with some torsion involved which resulted in his extremity possibly losing pulse for ~20min along with discoloration and decreased sensation. EMS noted color and pulse return on their arrival." The client was unable to provide hospital staff with additional information due to his cognitive deficits. The hospital discharged the client back to the facility in good condition following evaluation.

During an interview, a caregiver stated she received a call from the client's spouse while in the presence of the AP. She stated the spouse asked her who was responsible for the client's care that evening because the client needed help. The caregiver stated she immediately passed on the information to the AP and that the AP said he had just been there. The caregiver stated she told the AP to go back, and that the AP said he would. The caregiver stated she went about her normal routine caring for clients and did not observe whether the AP went to the client's room. The caregiver stated after the client's fall she asked the AP if he had gone to check on the client when the spouse called and that the AP told her yes, he had.

During an interview, the AP stated that he recalled that he toileted the client before 3:30 p.m. despite the client's care plan instructing staff to toilet the client at 4:00 p.m. The AP stated he then escorted the client to dinner and escorted him back to his room after dinner. The AP stated he left the client in his wheelchair, despite the client's care plan indicating that the client could not remain in his wheelchair for more than one hour at a time. The AP stated that he did not toilet the client following dinner because the client did not request it. The AP denied that another caregiver informed him of the spouse's call, and the AP denied awareness that the client had pushed his call light. The AP stated that he did not toilet the client at 6:00 p.m. as directed by the care plan.

During an interview, the client's spouse stated at around 5:30 p.m., the client called her to say he needed to use the bathroom. The spouse stated she then called the facility to alert staff of the client's need, but later found out that the caregiver did not go in to assist the client. The spouse stated the client's fall resulted in bruising to the client's arm. The spouse stated after the incident she moved the client to another facility, and the client had since passed away.

In conclusion, neglect was substantiated. Due to the AP's failure to follow the client's plan of care and respond to the client's needs, the client initiated a self-transfer, which resulted in the client's fall and arm becoming pinned in the client's wheelchair spokes.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"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.

Vulnerable Adult interviewed: No. The client was deceased at the time of the investigation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by the facility. The facility re-trained staff during an all-staff meeting regarding call light response.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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.

cc:
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Shorewood Police Department
Shorewood City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27108	A. BUILDING: _____ B. WING _____	C 12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER HOME CARE	2722 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407

(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, the Minnesota Department of Health issued a correction order pursuant to a survey. 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: On December 30, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL27108025C/#HL27108024M. At the time of the survey, there were #30 clients receiving services under the comprehensive license. The following correction order is issued for #HL27108025C/#HL27108024M, tag identification 0325.	0 000		
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: (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;	0 325		

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0 325	Continued From page 1 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one client (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On January 13, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction required. Please refer to the public maltreatment report for additional details.	