MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Accessible Space Inc. ASI South
2550 University Ave W. Suite 330N
St. Paul MN, 55114
Ramsey County

Report #: HL27312001

Date: February 17, 2015

Date of Visit: September 9, 2014
Time of Visit: 10:00 a.m. to 3:30 p.m.

By: Elizabeth Swan, 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 a client was neglected when the cushion in the client's wheelchair would not stay inflated and the staff did not replace it, causing pressure ulcers that will require surgical repair.

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 preponderance of evidence, neglect occurred when the staff failed to ensure a pressure-relieving cushion functioned properly, and failed to implement additional interventions to eliminate pressure. As a result, the client developed a pressure ulcer and required surgical intervention for closure.

The client's diagnoses included progressive multiple sclerosis (MS) with right sided weakness, back pain, and neurogenic bladder. The client was non-ambulatory and required complete assistance with activities of daily living (ADL) skills which included dressing, grooming, bathing, eating, transfers with a mechanical lift, and positioning. The client required staff assistance with repositioning due to the high risk for pressure ulcer development.

Staff documented a small pressure ulcer on the client's sacrum, and seventeen days after this documentation, the client's physician identified the deflated pressure-relieving cushion in the client's wheelchair. The facility staff had knowledge of the defective cushion. Although staff attempted to re-inflate the cushion, the facility failed to take measures to replace or repair the cushion.

The client's record revealed unlicensed personnel had documented almost daily, since the client was seen by the physician, wound changes that included an increase in size with an increase in drainage, odor and that the wound was now black in color, with no additional interventions to eliminate the pressure when the client was sitting.

The client's physician stated the client is unable to reposition him/herself to relieve pressure while seated in the wheelchair, and the deflated pressure-relieving cushion contributed to the development of the pressure ulcer. The physician referred the client to the wound clinic for surgical repair of the pressure ulcer.

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 had policy and procedures in place; however, multiple staff over a period of two months failed to address the defective pressure relieving wheelchair cushion or implement interventions to eliminate the pressure ulcer.

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 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):
A revisit conducted on October 28, 2014, found the facility in compliance with state regulations.

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: 0

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: VA directs his/her own care

Did you interview the resident(s) identified in allegation: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 8

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 5

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: _____	

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: Health Regulation Division – Home Care Assisted Living Program
Minnesota Board of Nursing
Rochester City Police Department
Olmsted County Attorney
Rochester 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
	H27312	A. BUILDING: _____ B. WING _____	C 09/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESSIBLE SPACE INC ASI SOUTH	2550 UNIVERSITY AVE W STE 330N SAINT PAUL, MN 55114

(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 conducted to investigate case #HL27312001. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the Minnesota 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 OCT 17 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.	
0 030	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	0 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Director of Program Services | TITLE | (X6) DATE: 10-13-2014

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure one of one (C1) client identified with pressure ulcers received the necessary care and services to prevent the development of a pressure ulcer, and that an assessment was completed by a registered nurse (RN) and interventions implemented to promote healing and minimize the risk for the development of further pressure ulcers. The findings include: Client #1 (C1) who was wheelchair bound had a deflated pressure relieving wheelchair cushion. The client developed two pressure ulcers. C1's record lacked evidence of documentation that an assessment was completed by the RN for causative risk factors when redness of the areas first appeared. C1 was admitted for services on October 4, 2010, with diagnoses that included progressive multiple sclerosis (MS) with right sided weakness, back pain, and neurogenic bladder. C1's individual service plan revised on July 16, 2014, identified C1 required complete assistance with activities of daily living (ADL) skills which included dressing,	0 030	RN was counseled and disciplined on 10/10/2014 for not following the policy of Comprehensive Nursing Assessments. This policy identifies that the RN will monitor and reassess as needed based on changes in the resident's needs. All Care Plans will indicate the type of cushion and the daily care of the cushion. This task for all residents that use a pressure cushion will be completed by 10/24/2014.	

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0 030	Continued From page 2 grooming, bathing, eating, transfers with a mechanical lift, and positioning. The client was non ambulatory. The information identified C1 was unable to move self without assistance from another person, and that one staff was required to assist with repositioning during the night hours. Other delegated nursing services included medication administration, range of motion (ROM), application of a right arm brace, and catheter care. On September 9, 2014, at 11:00 a.m., C1 was observed seated in the wheelchair. C1 was noted to have a white towel appearing item rolled up an placed under the left leg. C1 stated it was placed there to relieve pressure due to the wheelchair cushion not keeping air. C1 was not sure how long the cushion had malfunctioned. C1 stated he/she had impaired sensation, and spent most of the day seated in the wheelchair. C1 stated wound care was provided by the ULP's and was not aware when or how often the RN assessed the wounds. The facility policy and procedure Comprehensive Nursing Assessments revised November 1, 2013, identified ongoing resident monitoring and reassessment must be conducted as needed based on changes in the resident's needs. On review of the client's record it was noted that on July 17, 2014, documentation in the progress notes, by an unlicensed personnel (ULP), identified C1 had an open area on the left inner thigh that was about one inch in length. The ULP documented the area appeared to be the result of a "blister broken open." The documentation indicated the ULP applied antibiotic ointment to the area. The client's record lacked evidence of documentation that the open area was assessed	0 030	On 10/07/2014 a Repositioning flow sheet was implemented. This form will require staff to document the position of the resident that the staff had repositioned to, the time that the resident was repositioned and if the resident refused the reposition task. A mandatory all staff meeting held on 10/15/2014 included the introduction of the new Positioning form. On 7/22/2014 the Site Supervisor called to make an appointment with Med City Mobility. The reason for the call was to request an appointment to have them investigate the malfunction of the resident's RoHo cushion. Please see attached document 1 of 3.	

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0 030	Continued From page 3 by the RN, or that the RN notified the client's physician. There was no evidence of documentation that risk factors were identified or that interventions were implemented to promote healing of the open area. On August 7, 2014, the ULP documented, in the progress notes, the client had called three times and requested repositioning because his/her "butt hurting". The ULP documented the client had an open sore in the crack by the tail bone about the size of a pencil eraser. The ULP documented that duoderm was applied to the open area. The client's record lacked evidence of documentation that the open area was assessed by the RN, or that the RN notified the client's physician. There was no evidence of documentation that risk factors were identified or that interventions were implemented to promote healing of the open area. A Medical Referral Form completed by C1's physician and dated August 8, 2014, identified C1 had a decubitus ulcer stage 2 (superficial open sore in the upper layer of skin, may look like a blister, abrasion, scrape or shallow crater), and an infected ulcer of the inner thigh/buttock. Orders on the referral form and signed by the physician were; 1. Please apply duoderm to coccyx area daily, 2. For the inner thigh area apply absorbent tegaderm daily, and 3. Keflex (antibiotic) one tablet four times a day times seven days. The client was to be reevaluated by the physician in one week. The medication administration record (MAR) and treatment administration record (TAR) for the month of August 2014, identified C1 received the antibiotic starting on August 9, 2014, however; documentation for the duoderm dressing change	0 030	The Mayo Clinic was notified by the site RN of a symptom assessment on 8/7/2014 at 12:10 pm. Please see example 2 of 3. A mandatory all staff meeting held on 10/15/2014 educated staff on the revised When To Call The Nurse policy. This policy identifies when a new medication or treatment order is given to a resident that the staff must notify the nurse for direction and procedure for the new medication or treatment order.	

Minnesota Department of Health

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0 030	Continued From page 4 to the coccyx ulcer started on August 14, 2014 and the tegaderm dressing change to the left inner thigh ulcer did not start until August 13, 2014. On August 11, 2014, the ULP documented the "sore on his/her butt doesn't seem to be getting better". On August 13, 2014, a Care Plan Addendum was completed by RN-A. The information was as follows: "Please be aware of daily dressing changes for (name). Directions for Tegaderm and Duoderm are written in MAR. Please document in the MAR appearance of wounds." The client's record lacked evidence of documentation that the RN assessed C1's pressure ulcers. On August 17, 2014, the ULP documented the "sore on the buttock is wider, deeper, and was pusing". The documentation indicated the ULP applied a new duoderm. The documentation did not identify the location of the buttock wound. On August 29, 2014, the ULP documented that the "pus" from the wound on the tailbone had soaked through the client's pants. On August 30, 2014, the ULP documented "another sore coming". There was no documentation as to the location or appearance of the "sore". On September 3, 2014, the ULP documented the "sore on the tailbone has a black spot about the size of a nickel." The client's record lacked evidence of documentation that the RN completed an assessment or that C1's physician was notified.	0 030	The RN was counseled and disciplined on not addressing new orders and other documentation in her mail box from 8/11/2014-8/13/2014. RN was counseled and disciplined on not documenting that she assessed the pressure ulcer on 8/13/2014. On 10/7/2014 a Skin Care Sheet was implemented and staff were instructed that it is required to monitor skin and document any noted body marks. This documentation will be completed weekly on shower day(s) or as directed by the RN. A mandatory all staff meeting will include further communication regarding the new Skin Care Sheet. The Mayo Clinic was notified by the site RN on 9/2/2014 with concerns about the residents pressure ulcer. RN reported that the area looks worse, has an odor and appears to be larger in size. RN requested that the resident been seen by her primary physician. Please see example 3 of 3.	

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0 030	Continued From page 5 The client's record lacked documentation of further physician follow up regarding the status and treatment of C1's pressure ulcers since August 8, 2014. However; review of information received by the Minnesota Department of Health Office of Health Facility Complaints, identified C1 was evaluated on August 25, 2014. The information identified C1's wheelchair cushion was deflated on the left side, thus C1 was sitting on hard metal which likely created the ulcers and made them worse. The information also identified that due to the extent of the ulcers surgical repair will be needed. On September 9, 2014, at 12:00 p.m. unlicensed personnel (ULP) B, verified C1's wounds were not improving. ULP-B also verified awareness of the client's wheelchair cushion not holding air for about a week or two. ULP-B stated the wound care was completed as directed by the client and the client's care plan. On September 9, 2014, at 12:45 p.m., ULP-C stated awareness of the client's wheelchair cushion not holding air was about two weeks ago. ULP-C stated C1 brought it to his/her attention when asked to reinflate the cushion. ULP-C also stated C1 sat in the wheelchair all day. On September 9, 2014, at 1:30 p.m., RN-A verified no assessment was completed on July 17, 2014, when C1 was identified with an open area to the left inner thigh. In addition RN-A verified no assessment was completed on August 7, 2014, when C1 was identified with an open area on the coccyx. RN-A stated physician orders are implemented for wound care if duoderm, otherwise if more is needed an outside agency would do the treatment. RN-A stated there was no protocol in place for wound care. The RN	0 030	Resident Care Plans will include detailed information in regards to the type of pressure relieving pad that the residents use while sitting in their wheelchair. This detail will include the type of cushion and the daily care per recommendation from each manufacturer. ASI will suggest to all residents using a pressure relieving pad to have a backup pad in case of malfunction.	

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0 030	Continued From page 6 stated a weekly or ten day assessment of a pressure ulcer would be appropriate. The RN verified no assessments were completed that identified the location, size and appearance of C1's wounds or that causative risk factors were assessed and addressed to minimize the risk for further progression and development of pressure ulcers. On September 9, 2014, at 2:05 p.m., ULP-D stated C1's wounds have gotten "progressively worse." ULP-D stated the open sore on C1's coccyx was now the size of quarter to silver dollar with pale yellow foul smelling drainage. ULP-D stated the area surrounding the sore was red and ~~irritated looking. ULP-D also stated the sore was~~ also causing C1 pain. ULP-D expressed knowledge of C1's wheelchair cushion not holding air for about one to two weeks. ULP-D stated he/she was made aware of this only when C1 asked to have the cushion reinflated. On September 9, 2014, at 2:45 p.m., The site supervisor verified the RN is responsible for the direct supervision of care. The supervisor also verified awareness of C1's malfunctioning cushion, but was not aware if other measures had been implemented to minimize pressure. The site supervisor stated he/she was aware of the magnitude of the pressure ulcers Labor Day weekend. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	0 030	Site Supervisor was counseled and disciplined on 10/10/2014 for not addressing the malfunction of the pressure relieving air cushion after is was reported on 9/1/2014.	

AH Form Approved
12/23/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H27312	A. Building B. Wing	10/28/2014

Name of Facility	Street Address, City, State, Zip Code
ACCESSIBLE SPACE INC ASI SOUTH	2550 UNIVERSITY AVE W STE 330N SAINT PAUL, MN 55114

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 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 10/28/2014	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	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: 9/19/2014

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