Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL27794009M
Compliance #: HL277940010C

Date Concluded: January 6, 2020

Name, Address, and County of Licensee Investigated:
Ecumen Seasons at Apple Valley
15359 Founders Lane
Apple Valley, MN 55124
Dakota County

Facility Type: Home Care Provider

Investigator's Name: Yolanda Dawson, 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: Neglect occurred. The alleged perpetrator (AP) neglected the client when he failed to complete safety checks and bathroom assist according to the client's service plan and the client fell out of her bed and broke her hip. Subsequently, the client was unable to recover from the injury and passed away five days later.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the client's service plan or respond to her motion sensor. The client fell out of bed at 3:51 a.m. and broke her hip. She unable to recover from her injury and passed way five days later.

The investigation included interviews with facility staff members, including administrative staff, unlicensed staff, and facility residents. The client's medical records and the AP's employee file were reviewed. In addition, the investigator observed memory care staff provide cares and pass medications.

The client's medical diagnosis included Alzheimer's disease, anxiety and major depressive disorder, osteoarthritis, and chronic kidney disease Stage III. The client received services from the comprehensive home care provider for medication management, behavioral support, repositioning, bathing and grooming assistance, safety checks, transfer and toileting assistance, vital sign monitoring, and meal assistance. The client also received hospice services.

Review of the facility's internal investigation notes indicated an administrator viewed video footage from the date the client fell. The administrator documented that the video showed the AP walked in and quickly backed out of the client's room at 11:00 p.m. At 12:44 a.m., an unlicensed personnel (ULP) from assisted living sat down with the AP but left at 1:08 a.m., at which time the AP walked around the dining room, turned the lights on and then off, and sat down at 1:10 a.m. The same ULP returned at 1:15 a.m., sat down with the AP, and did not leave until 1:53 a.m. At 1:27 a.m., the AP was observed entering another client's room and backing out. The AP sat down at 1:31 a.m. and did not get up again until he responded to the client's motion sensor alert at 3:51 a.m. According to the timeline on the video, the AP did not do the client's scheduled safety checks at 1:30 a.m. and 3:30 a.m. or provide bathroom assistance at 2:30 a.m. The last time the AP was visualized in the client's room was at 11:00 p.m. During the internal investigation interviews, the AP and the ULP that came to help when the client fell out of bed stated the client had pulled off her brief, which was an indication that she had to use the bathroom.

During an interview, the administrator stated the memory care unit was staffed with one ULP during the night shift with one ULP floating in-between the two memory care units. The administrator stated that during the internal investigation, it was found that the client had cares scheduled to be completed during the middle of the night that should have been done before the fall occurred that was not completed by the AP. The administrator stated the video showed the AP sitting for long periods of time and was never seen going into the client's room to perform cares. The administrator stated the AP was no longer employed at the facility.

During an interview, the AP stated he completed his first round to see that all clients were safe, in bed and dry at 11:00 p.m. The AP stated his next round was done at approximately 1:10 a.m., at which time he checked on only the clients that were a fall risk which included the client in question. The AP stated he did not complete the client's scheduled 2:30 a.m. bathroom assist because he could not do it by himself, and he did not have help. The AP stated he did not call the assisted living person for help because she had her own schedule to follow.

In conclusion, neglect was substantiated.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility posted instructions for all employees to follow the care plan, document appropriately, and to respond to pedant calls/motion sensors in a timely manner. All employees were required to sign that they understood the requirements and agreed to do them. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Dakota County Attorney
Apple Valley City Attorney
Apple Valley Police Department
Hennepin County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27794	A. BUILDING: _____ B. WING _____	C 12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

(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(s) 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 10, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL27794010C/#HL27794009M. At the time of the survey, there were #46 clients receiving services under the comprehensive license. The following correction order is issued for #HL27794010C/#HL27794009M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
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:	0 325		

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0 325	Continued From page 1 (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; This MN Requirement is not met as evidenced by: Based on Observation interview and document review, the licensee failed to ensure that one of seven clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: December 10, 2019, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the 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 (PoC) is required. Refer to the maltreatment public report for details.	