DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Ecumen Prairie Hill		**Report Number:** HL27944006	**Date of Visit:** September 25, 2017
Facility Address: 1305 Marshall Street		**Time of Visit:** 9:30 a.m. to 5:30 p.m.	**Date Concluded:** February 12, 2018
Facility City: St. Peter		**Investigator's Name and Title:** Kathleen Smith, DNP, RN, PHN, Special Investigator	
State: Minnesota	**ZIP:** 56082	**County:** Nicollet	

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged a client was abused when staff/alleged perpetrators (AP#1, AP#2, AP#3) verbally threatened to strangle the client if s/he attempted to leave the unit at the facility. It is also alleged the APs barricaded the exit with a mechanical lift to prevent the client from leaving the unit.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of the evidence, abuse is substantiated. The alleged perpetrators (AP) confined the client to his/her apartment or the unit by blocking the doorway with a sit-to-stand lift.

Based on a preponderance of the evidence, the allegation of verbal abuse is inconclusive. There was not a preponderance of evidence whether or not the APs made disparaging, derogatory, humiliating, harassing, or threatening statements aimed at the client.

The client resided in a secured unit and received services from the home care provider. The client had dementia with hallucinations and required assistance with activities of daily living, as well as frequent redirection due to wandering and exit seeking behaviors.

On the date of the incident, AP #1 placed the sit-to-stand lift either in front of the door to the unit or in front of the door to the client's apartment, in order to confine the client. This intervention was not part of the client's care plan, but other direct care staff indicated it was used on other occasions to address the client's exit seeking behavior.

During an interview, AP #1 stated the sit-to-stand lift was placed in front of the memory care door. AP #1 stated this was done because there was only one staff person in memory care, another client required checks every 30 minutes, and the client was wandering. During the home care provider investigation, AP #1 stated the sit-to-stand lift was used to block the client's door because the client previously left the memory care area while cares were provided to other clients and was able to get outside the facility. Additionally, AP #1 stated the night shift required more staff, and administration was aware of that need.

During an interview, AP #2 stated s/he had been taught by other staff to place the sit-to-stand lift in front of the client's door, and had done this a few times. AP #2 also stated the client was able to get out of memory care several times and was located outside when the weather was getting colder. The home care provider investigative report indicated AP #2 denied making any malicious remarks to the client, and that a former staff person showed him/her to place the sit-to-stand lift in front of the client's door when the client was exit seeking. Additionally, AP #2 stated administration was aware more staff were needed on nights and a float staff was scheduled a couple of times a month.

During an interview, AP #3 denied observing the use of the sit-to-stand lift in front of the doors or hearing any malicious comments made toward clients. AP #3 denied blocking the door or making malicious comments toward clients. AP #3 stated the client had left memory care and was discovered outside during the day. This AP also stated at night it is difficult to hear the alarms when providing cares in the clients' rooms.

During an interview, home care provider administration stated the float position was a fairly new position for all shifts. A review of a home care document dated in May indicated a float staff was to work the day and night shifts, but a review of the September schedule indicated there was no scheduled float staff.

The home care provider investigated the allegations, APs #1 and #2 were terminated and AP #3 received retraining.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

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:

Multiple staff members used an inappropriate device and technique to confine a client. The home care provider was aware of the needs of the client and had determined another staff member was necessary to meet the needs of the clients, but failed to schedule another staff member in a way which would address

those needs.

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 for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult.

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.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: None

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, 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: Disjointed reponses

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant 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:

- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Meals
- [x] Facility Tour

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: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

St. Peter Police Department

Nicollet County Attorney

St. Peter City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27944	A. BUILDING: _____ B. WING _____	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN PRAIRIE HILL	1305 MARSHALL STREET SAINT PETER, MN 56082

(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, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 25, 2017, a complaint investigation was initiated to investigate complaint #HL27944006. At the time of the survey, there were 61 clients that were receiving services under the comprehensive license. The following correction orders are issued.	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 Nursing Homes. 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 and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are 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.	
0 325 SS=D	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	0 325		

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0 325	Continued From page 1 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 interview and document review, the home care provider failed to ensure one of one clients (C1) was free from maltreatment (abuse), when home care provider staff blocked the client's door with an EZ Stand (a piece of equipment use to help client's sit and stand or a lift) in order to confine the client to the client's room. This 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 is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: The client lived on a secured unit and had a diagnosis of senile dementia with delusions. The client received services from the home care provider including assistance with activities of daily living and medication management. A review of the Service Plan, effective May 17, 2017, indicated the client wandered and had exit seeking behaviors. The Care Plan reviewed June 27, 2017, revealed the client was at risk for elopement and staff were to monitor the client's location at all times.	0 325		

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0 325	Continued From page 2 A review of home care provider investigative documents revealed Unlicensed Personnel (ULP)-D confirmed the client had eloped from the facility, no reports were completed, and the client's door was then blocked using a "sit to stand lift." During an interview on September 29, 2017, at 3:57 p.m., ULP-D stated maltreatment of vulnerable adults was discussed during orientation, as well as reporting and ways to approach clients. During the night shift, there was only one staff member scheduled in memory care and another staff member scheduled in the assisted living area. There was supposed to be a float staff member, however this staff member was onsite until 2:00 a.m. whereas clients were to be checked on at 4:00 a.m. ULP-D stated one night, no assistance was available to ULP-D in memory care, another client required checks every 30 minutes and C1 was continuously trying to exit, so ULP-D placed the EZ Stand in front of the memory care entrance door. On the night of the incident, a float worked until 2:00 a.m., the client was constantly up, and the EZ Stand was requested. During an interview on September 25, 2017, at 2:39 p.m., ULP-W stated the EZ Stand was observed in front of the door to the client's apartment and was moved by ULP-W. Another time ULP-W observed the client standing on the EZ Stand. During an interview on September 25, 2017, at 4:23 p.m., ULP-C stated the client did exit seek and redirection was provided. Additionally, it was stated that at night the alarm could not be heard if staff was in the room of another client. ULP-C stated the client was able to leave the memory	0 325		

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0 325	Continued From page 3 care and was observed outside during the day without an escort. A document dated May 11, 2017, indicated the night shift is from 10:15 p.m. to 6:15 a.m. and staffing consists of one resident assistant for assisted living, one for memory care, and one float. However, a review of the home care provider staff schedule for the month of September 2017 revealed only two staff were scheduled for the night shift. The employee Abuse Prevention Plan acknowledgement form revealed staff are to treat clients with respect and not mistreat clients in any way. The home care provider Culture Pledge, indicates clients will be treated with respect and staff will follow policies and safety rules. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 325		