Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL28279029M

Date Concluded: February 3, 2020

Name, Address, and County of Licensee Investigated:
Oxford Property Management, LLC
206 South Broadway STE 500
Rochester, MN 55904
Olmsted County

Name, Address, and County of Housing with Services location:
Primetime Living
105 North Broadway
Rochester, MN 55906
Olmsted County

Facility Type: Home Care Provider

Investigator's Name: Christine Bluhm, 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 when the client fell in the bathroom and called out for help while the alleged perpetrator (AP) slept in lounge. Another client had to find staff (the AP) to help the client.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP was responsible for the maltreatment. The AP was sleeping during her scheduled shift when client #1 could not get up off the toilet, pushed her call pendant and screamed for help, and was subsequently wedged on the toilet for hours yelling for help. Client #1 required the assistance of the fire department to get off the toilet.

The investigation included interviews with facility staff members, client #1, and other clients at the facility. The investigator reviewed documents related to the client's medical records, photographs of where the incident occurred, and client service plans.

The client #1's diagnoses included left-sided hemiplegia (weakness), history of stroke, obesity, diabetes, major depression, and chronic pain syndrome. Client #1 received services from the home care provider for assistance with medications, bathing, dressing, toileting, and safety checks.

Review of client #1's service plan indicated she required toileting assistance every two hours during the night. The AP was the scheduled staff person assigned to assist client #1 with toileting the night of the incident.

During interview, client #1 stated when she went to the bathroom around 2:00 a.m., the legs on the over-the-toilet commode gave out. She stated she became wedged in that position and could not get up. Client #1 stated she pushed the call pendant for help but no one came. She stated she screamed out for help and another client (client #2) heard her screams and went to find staff. Client #1 stated it was around 5:00 a.m. when the fire department arrived and assisted her.

During interview, client #2 stated she heard client #1 screaming for help around 4:30 a.m. and proceeded to look throughout the building for a staff member. She stated she then found the AP asleep on the couch in the lounge area. The AP was curled up in a blanket with the staff pendant pager next to her.

During interview, the home care service manager stated client #1's temporary toilet commode was too small and a new one was being delivered. With client #1's weight, she stated the front commode legs buckled, bent forward and the client could not get up. The manager also stated he interviewed the AP two different times and found the AP's accounts of the incident to be inconsistent. The manager stated the AP's job position was an awake position, and there was a zero tolerance policy for sleeping during shift time.

During interview with the investigator, the AP denied the allegation that she fell asleep on the night of the incident. The AP stated she was awake, resting with her feet up, and studying. The AP stated that she heard client #1's screams and started in that direction when client #2 found her.

In conclusion, neglect was substantiated. The AP did not follow facility policy to remain awake during her shift and did not respond to client #1's screams for help. Client #1 was unable to get up on her own and remained wedged on the toilet for hours until client #2 went for help.

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: Yes.
Family/Responsible Party interviewed: Client requested not to interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted a mandatory meeting for all staff about the awake policy and zero tolerance for sleeping on the job. The AP is no longer was employed by the facility.

Action taken by the Minnesota Department of Health:
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
County Attorney for Olmsted County
Rochester City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28279	A. BUILDING: _____ B. WING _____	C 12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD PROPERTY MANAGEMENT LLC	206 SOUTH BROADWAY ROCHESTER, MN 55904

(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 12/26/19, the Minnesota Department of Health initiated an investigation of complaint #H28279027M & HL28279029M. At the time of the survey, there were no clients receiving services under the comprehensive license; thus, compliance issues were not investigated as the facility license was closed at the time of the investigation (#HL28279028C & HL28279030C). The following correction order is issued for #HL28279029M, 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.	
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	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28279	A. BUILDING: _____ B. WING _____	C 12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD PROPERTY MANAGEMENT LLC	206 SOUTH BROADWAY ROCHESTER, MN 55904

(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
0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On January 22, 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		