MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Summit Hill Senior Living
1824 Old Hudson Road
St. Paul, Minnesota 55119
Ramsey County

Report #: HL28604002

Date: July 10, 2014

Date of Visit: June 17, 2014
Time of Visit: 7:30 a.m. – 4:30 p.m.

By: Lisa Jacobsen, 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 s/he was not provided with any fluids, food, or monitoring for more than 24 hours because staff was unaware the client was admitted to the memory care unit. When found, the client had abrasions on top of her/his thighs and forehead.

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 a preponderance of evidence, neglect occurred when staff failed to provide the client with food, fluids, medications, personal care and supervision from 7:45 p.m. until 2:23 p.m., the following day. (Eighteen hours and thirty-eight minutes)

The client had a diagnosis of dementia, received hospice care and recently moved from the assisted living portion of the facility, to the memory care unit of the facility due to requiring increased care and supervision. The client was oriented to self and family but not always oriented to person place and time and utilized a wheelchair for mobility. On the overnight shift (10:30 p.m. – 6:00 a.m.), the client was to receive a "Safety Check" at 1:30 a.m. and assistance to the bathroom. On the day shift (6:00 a.m. – 2:00 p.m.), the client was to receive the following services: At 7:30 a.m. medication administration, assistance washing up, and dressing. At 10:00 a.m., the client was to receive a "Safety check" and reminder to use the toilet. At 11:15 a.m., the client was to receive a "Safety check", assistance to the toilet as needed, escort to the dining room and assistance to eat. In addition, staff were to visually check on the clients in the memory care unit every hour.

Staff found the client at 2:15 p.m., on the toilet with her/his head wedged between the toilet and the wall. The client had an abrasion on her right forehead. The client had a large red area on her/his left side between the bottom rib and upper hipbone. The area was 7 cm (centimeter) x 15 cm, slightly raised, and tender to touch. The client also has two red areas on her/his right inner thigh that measured 1.5 cm x 18 cm and two red areas on her/his left inner thigh. The client was unable to tell staff how s/he got to the bathroom and/or how long s/he had been sitting on the toilet.

The client died the following morning. The client's death certificate indicated the immediate cause of death was "Atherosclerotic Cardiovascular Disease". The medical examiner's report indicated the "Final Anatomic Diagnosis" was Atherosclerotic cardiovascular disease with narrowing of the lumens and right coronary artery, Cerebral atrophy, Contusions of the body, Left lateral rib fractures, and extreme osteoporosis.

Interviews revealed the client moved from the assisted living portion of the facility to the memory care unit of the facility on the day shift. The evening shift provided personal cares to the client. The staff person on the overnight shift stated she did not provide any care to the client during her shift because she was not aware that the client moved from the assisted living portion of the facility to the memory care unit. The staff person on the day shift the following day stated she did not provide any personal cares to the client because she did not know the client was on the memory care unit in her/his room during her shift. Both staff stated there was no

documentation in the communication book regarding the client's move/transfer to the memory care unit, nor did staff report at the change of shift to them that the client was in her/his room on the memory care unit. Both staff acknowledged that the client was listed on their service schedule to receive services. In addition, at change of shifts, staff was to do "walking rounds" together so staff knew what the status of each client was at the beginning and end of their shifts. The "walking rounds" did not occur at change of shift from evenings to overnight and from overnights to days shift.

A review of the facility's surveillance camera footage revealed the following: At 7:41 p.m., a staff person went into the client's room and left the client's room at 7:45 p.m. After 7:45 p.m., a staff person did not go into the client's room until 2:23 p.m. the following day. "Walking Rounds" at change of shift did not occur, nor was the client checked on every hour by the staff person who knew the client was there from 7:45 p.m. until the end of the staff person's shift at 10:00 p.m.

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 is responsible for the neglect, due to multiple breakdowns in policies/procedures by more than one staff. In addition, the facility failed to adequately supervise the caregivers to ensure policies/procedures were implemented. Although the facility utilized a written communication book to report to oncoming shifts changes/happenings with clients on their shifts, staff on the day/evening, and overnight shift did not document in the communication book that the client moved from the assisted living portion of the facility to the memory care unit of the facility. Although there was a "Memo" signed by the employee in some of the staffs' personnel files explaining the expectation of "Walking Rounds", other staff did not receive this memo. Interviews indicated that some staff felt they did not need to do "Walking Rounds" at change of shift because they knew the kind of work that the staff person did, and trusted the staff person that the work was done. Personal cares were listed on the overnight shift service schedule and the day shift service schedule, but staff did not provide the listed services. In addition, the evening staff person who knew the client was in her/his room did not check on the client every hour as required after 7:45 p.m. until the staff person's shift ended at 10:00 p.m.

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 Not Met

The requirements under State Licensing Rules for Home Care (MN Rules Chapter 4668) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

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

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):

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: The client was deceased.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility Self-Report

If unable to contact complainant, 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: The client was deceased.

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: 0

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 8

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: Review of the Facility Surveillance Camera Video	

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: Division of Compliance Monitoring - Licensing & Certification
St. Paul City Police Department
Ramsey County Attorney
St. Paul City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28604	A. BUILDING: _____ B. WING _____	C 06/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1870 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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 #HL28604002. 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	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		

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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 observations, interview and document review, the licensee failed to ensure that care and services were provided according to an up-to-date plan for one of one client (C1) reviewed. The findings included: C1 did not receive any personal care, medications, food or fluids from 7:45 p.m. on May 24, 2014 until 2:23 p.m. on May 25, 2014. C1's record was reviewed. C1's narrative note dated May 2, 2014 indicated C1 was oriented to self and family, but was not always oriented to person or place and time. The note indicated that the client was scheduled to move from the assisted living portion of the facility to the memory care unit within the next week. C1's Service Schedule dated May 24, 2014 for the 10:30 p.m. -7:00 a.m. shift indicated at 1:30 a.m., C1 was to have a "Safety Check" and "Take to the bathroom." C1's Service Schedule dated May 25, 2014 for the 6:00 a.m. - 2:30 p.m. shift indicated staff were to provide the following services to the client: At 7:30 a.m. "Med (medication) assist-Give her pills, Assist to get washed up and dressed." At 10:00 a.m. a "Safety	0 030		

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0 030	Continued From page 2 check" and "Remind to use toilet and assist as needed." At 11:15 a.m. a "Safety check, Assist to toilet as needed, Escort to dining room in memory care, Assist to eat." In addition, the Service Schedule indicated that all tenants in the memory care unit must be visually checked on every hour. C1's "Notes" dated May 25, 2014 at 10:12 p.m. indicated the following; "Staff reported that the client was found at 2:15 p.m. on the toilet with her head wedged between the toilet and the wall. The client was assessed by this writer at 5:00 p.m. Client has abrasion on her right forehead. She has a large red area on her left side between bottom rib and upper hip bones. The area is 7 cm (centimeter) x 15 cm and slightly raised. The area is tender to the touch. The client also has 2 red areas on her right inner thigh that measure 1.5 cm x 18 cm and 2 red areas on the left inner thigh. These areas match to the toilet seat. The client has pain with sitting her up. It is undetermined at the amount of time the client had been on the toilet seat." Observations of the facility's surveillance camera footage was viewed with the Housing Director on June 17, 2014 at 1:15 p.m. The camera footage showed that on May 24, 2014 at 7:41 p.m., unlicensed staff person (ULP)-E went into C1's room ULP-E was observed to leave C1's room at 7:45 p.m. After 7:45 p.m., a staff person was not observed to go into C1's room until 2:23 p.m. on May 25, 2014 (18 hours and 38 minutes later) When interviewed June 17, 2014 at 3:30 p.m. ULP-E stated on May 24, 2014, C1 moved from the assisted living portion of the facility to the memory care unit of the facility. ULP-E stated she worked the afternoon shift (2:15 p.m. - 10:45 p.m.) on May 24, 2014. ULP-E stated at the end	0 030		

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0 030	Continued From page 3 of her shift, she told ULP-D that C1 had transferred to the memory care unit and that she needed to check on C1 during the night. ULP-E stated she did not document that C1 had been transferred to the memory care unit in the communication book, because C1 transferred to the unit on the day shift not the evening shift. When interviewed June 17, 2014 at 12:25 p.m., ULP-D stated she did not provide any care to C1 during the overnight shift (10:30 a.m.-7:00 a.m.) on May 24, 2014 into the morning of May 25, 2014. ULP-D stated she was not aware that C1 was on the memory care unit in her room during the overnight shift. ULP-D stated she did not receive verbal report from ULP-E that C1 had been transferred from the assisted living portion of the facility to the memory care unit of the facility, nor was there any documentation in the communication book that the transfer had occurred. When questioned why ULP-D's initials were on the Service Schedule at 1:30 a.m., that she had conducted a safety check and had assisted C1 to the toilet, ULP-D stated she did not provide those cares to C1. ULP-D stated the Service Schedule at the 1:30 a.m. time was titled "home visit." ULP-D stated that doesn't mean staff conduct a visit or provide cares. ULP-D stated if it was titled "toileting" then staff would assist the client with toileting. When interviewed June 23, 2014 at 10:00 a.m., ULP-H stated she did not provide any care to C1 during the day shift (6:00 a.m. - 2:30 p.m.) on May 25, 2014. ULP-H stated she did not know that C1 was on the memory care unit in her room during the day shift. ULP-H stated the overnight shift did not communicate to her that C1 was on the memory care unit, nor was there any documentation in the communication book that	0 030		

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0 030	Continued From page 4 C1 had been transferred to the memory care unit. ULP-H confirmed that C1 was listed on her service schedule to provide cares to periodically during her shift, but stated she thought the client listed on her Service Schedule was a different client who had the same name. When interviewed June 17, 2014, at 11:30 a.m., the Director of Nursing (DON) indicated that C1 had been spending most of her daytime hours on the memory care unit and her sleeping hours in her room on the assisted living the week prior to the incident,while she waited for family to move C1 to the memory care unit. The DON indicated that on May 24, 2014, the family moved C1 to the memory care unit. The DON stated staff were to document in the communication log any admissions or transfers to the unit. In addition, at change of shifts, staff were to do "walking rounds" together so they know what the status of each client was at the beginning and end of their shifts. TIME PERIOD FOR CORRECTION: Thirty (30) days	0 030		
06010	4668.0800 Subp. 3 Fulfillment of services Subp. 3. Fulfillment of services. A class F home care provider licensee must provide all services required by a client's service plan under part 4668.0815. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that services were provided as agreed to on the client's service plan	06010		

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06010	Continued From page 5 for one of one client (C1) reviewed. The findings included: Services were not provided to C1 from May 24, 2014 at 10:30 p.m. until 2:23 p.m. on May 25, 2014 as per the client's service schedule. C1's record was reviewed. C1's narrative note dated May 2, 2014 indicated C1 that the client resided on the memory care unit of the facility and was only oriented to self and family, and was not always oriented to person or place and time. The note also indicated the client was primarily wheelchair bound. C1's Service Schedule dated May 24, 2014 for the 10:30 p.m. -7:00 a.m. shift and indicated staff were to provide the following services to the client: at 1:30 a.m., C1 was to have a "Safety Check" and "Take to the bathroom." C1's Service Schedule dated May 25, 2014 for the 6:00 a.m. - 2:30 p.m. shift indicated the following: At 7:30 a.m. "Med (medication) assist-Give her pills, Assisted to get washed up and dressed." At 10:00 a.m. a "Safety check" and "Remind to use toilet and assist as needed." At 11:15 a.m. a "Safety check, Assist to toilet as needed, Escort to dining room in memory care, Assist to eat." In addition, the Service Schedule indicated that all tenants in the memory care unit must be visually checked on every hour. When interviewed June 17, 2014 at 12:25 p.m., unlicensed personnel (ULP)-D stated she did not provide any care to C1 during the overnight shift on May 24, 2014 into the morning of May 25, 2014. ULP-D stated she was not aware that C1 was on the memory care unit. When interviewed June 23, 2014 at 10:00 a.m., ULP-H stated she did not provide any care to C1 on the day shift of May 25, 2014. ULP-H	06010		

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06010	Continued From page 6 confirmed she did not conduct Safety checks, did not assist C1 with washing and dressing, did not take C1 to the toilet, did not administer C1's morning medications and did not assist the client to the dining room to eat lunch. ULP-H stated she did not know that C1 was on the memory care unit nor that C1 was in her room. TIME PERIOD FOR CORRECTION: Thirty (30) days	06010		

AH Form Approved
8/21/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H28604	A. Building B. Wing	8/20/2014

Name of Facility	Street Address, City, State, Zip Code
SUMMIT HILL SENIOR LIVING	1870 OLD HUDSON ROAD SAINT PAUL, MN 55119

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 08/20/2014	ID Prefix 06010 Reg. # 4668.0800 Subp. 3 LSC	Correction Completed 08/20/2014	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

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: 8/7/2014

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