Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Lifestone Health Care			HL29862001, HL29862002, HL29862003, and HL29862004	December 14, 2017
Facility Address: 319 7th Street			**Time of Visit:** 8:45 a.m. to 4:15 p.m.	**Date Concluded:** April 26, 2018
Facility City: Proctor			**Investigator's Name and Title:** Rhylee Gilb, RN, Special Investigator	
State: Minnesota	**ZIP:** 55810	**County:** Saint Louis		

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the alleged perpetrator modified the client's wheelchair resulting in a client falling backwards out of the wheelchair. The client suffered a head injury, was hospitalized and died.

☒ 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 evidence, neglect occurred when the alleged perpetrator (AP) removed the client's anti-tip bars from his/her wheelchair and the client fell backwards. The client sustained a severe head injury and died.

The client received services from a provider licensed as a comprehensive home care provider. The client's service plan indicated s/he required assistance with activities of daily living and medication administration. The client's registered nurse assessment indicated the client had impaired decision making and impaired mobility with limited range of motion. The client required a wheelchair for mobility. The client was cognitively intact and his/her own guardian. In addition, the client's care plan indicated the client required total assistance for shopping and to manage money for purchases. Shopping trips were to be planned in advanced and his/her family member assisted. The client required assistance of one person and a gait belt for all transfers.

The client's wheelchair was designed and manufactured specifically for his/her needs and measurements.

The wheelchair was delivered with the anti-tip bars attached on both wheels. Prior to the incident, the AP had received counseling about crossing boundaries with clients and being too personal. The client and AP requested from the home care provider administrator to be the client's personal care attendant (PCA) while off duty. The request was denied because it crossed employee to client boundaries. The client's family member stated the client had bought a car approximately three weeks before the incident.

The day of the incident, the AP worked, but was not assigned to the client's care. The client asked the AP to remove his/her anti-tip bars so it could fit in his/her car. The client planned to go to the store. The AP removed the anti-tip bars and assisted the client in the car. The AP then left, as his/her shift was over, and failed to inform the PCA assigned to the client s/he was leaving and that his/her anti-tip bars were removed.

At shift change, 3:00 p.m., the day shift PCA reported the evening shift PCA#1 the client was gone and staff were not sure when s/he would return. The client returned to the home care provider between 4:15 p.m. and 4:30 p.m. Evening shift PCA#2 assisted the client out of the car and unfolded his/her wheelchair. At 5:00 p.m., the client went to dinner and informed PCA#1 s/he had been to the store with the AP and looked for a new television. At 6:00 p.m., the client requested to go to bed. The client had a stool next to his/her bed for additional assistance into to bed due to his/her shorter stature. PCA#1 fixed the client's bed linen while the client tried to get his/her feet onto the stool. PCA#1 stated the client's left foot got caught under the stool and the client then used more force to try and get his/her foot up. The client's wheelchair flipped backward and the client fell, hitting his/her head. PCA#1 stated it happened quickly. PCA#1 bent down to see if the client was alright, and saw the client's eyes roll back and blood start coming from his/her head. PCA#1 ran to get PCA#2 to assist her. PCA#2 started cardiopulmonary resuscitation (CPR) and PCA#1 called the ambulance. PCA#1 stated the client's pulse was weak, his/her lips turned blue, and s/he had shallow breaths. The client was sent to the hospital.

After the ambulance left, the house coordinator arrived to the home care provider to determine what had happened. The house coordinator noticed the anti-tip bars were removed from the client's wheelchair and were laying on the floor underneath a window near the client's television. Both PCA#1 and PCA#2 stated they were never informed the anti-tip bars had been removed.

At the hospital, the client was admitted to the intensive care unit for respiratory arrest and anoxic brain injury (no oxygen to the brain). The client was placed on supportive measures which included intravenous fluids, antibiotics, was intubated and placed on a ventilator. After no progress of improvement, life support was discontinued and the client died.

The client's death record indicated cause of death was anoxic brain injury and respiratory arrest.

The home care provider administrator completed an investigation into the incident and the AP was terminated from employment. The administrator held an all staff meeting and provided re-training to the current staff. Staff were informed to monitor all equipment is in good working order prior to use, and removal of any equipment hardware requires approval from management.

The AP did not respond to a request for an interview.

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:

The AP had previous discipline about crossing client boundaries. The AP did not contact management for approval to remove the anti-tip bars, failed to let anyone know they were removed, and failed to inform anyone the client was leaving the home care provider.

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 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.

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] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes

- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records [x] Death Certificate

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: Two

Were residents selected based on the allegation(s)? (●) Yes ( ) No ( ) N/A

Specify: falls

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

( ) Yes ( ) No (●) N/A

Specify: client is deceased

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: client is deceased

Did you interview additional residents? (●) Yes ( ) No

Total number of resident interviews: Two

Interview with staff: (●) Yes ( ) No ( ) N/A Specify: ____________________

Tennessen Warnings

Tennessen Warning given as required: (●) Yes ( ) No

Total number of staff interviews: Five

Physician Interviewed: (●) Yes ( ) No

Nurse Practitioner Interviewed: ( ) Yes (●) No

Physician Assistant Interviewed: ( ) Yes (●) No

Interview with Alleged Perpetrator(s): ( ) Yes (●) No ( ) N/A Specify: Attempted phone and email

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:

☒ Use of Equipment

☒ Cleanliness

☒ Safety Issues

☒ Meals

☒ 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: wheelchairs and equipment

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Saint Louis County Medical Examiners

Proctor Police Department

Saint Louis County Attorney

Proctor 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
	H29862	A. BUILDING: ___ B. WING ___	C 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET DULUTH, MN 55810

(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, this correction order(s) has been 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 December 14, 2017, a complaint investigation was initiated to investigate complaint #HL29862001, HL29862002, HL29862003 and HL29862004. At the time of the survey, there were eight clients that were receiving services under the comprehensive license. The following correction orders are issued. 144A.44 Subd. 1 (14) is issued related to HL29862001, HL29862002, HL29862003, HL29862004	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 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 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=J	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 interview and document review, the licensee failed to maintain freedom from maltreatment for 1 of 3 clients (C1) reviewed, when the a client's anti-tip bars were removed from the client's wheelchair and the client fell backwards. The client sustained a severe head injury and died. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was 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 the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1's service plan, dated March 23, 2017, indicated C1 required assistance with activities of daily living and medication administration. C1's registered nurse (RN) assessment dated August 28, 2017 indicated C1 had impaired decision making, impaired mobility, and limited range of motion. C1 required the use of a wheelchair. C1 was cognitively intact and his own guardian. C1's care plan, dated February 20, 2017 was reviewed. C1 required total assistance for shopping and to manage money for purchases. Shopping trips were to be planned in advanced	0 325		

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0 325	Continued From page 2	0 325		

and C1's family member assisted. C1 required assistance of one person and a gait belt for all transfers.

During an interview on December 14, 2017, at 10:30 a.m., Administrator-A stated C1's wheelchair was designed and manufactured specifically for his needs and measurement. The wheelchair was delivered with the anti-tip bars attached on both wheels. Administrator-A stated personal care attendant (PCA)-F had counseling prior to the incident about crossing boundaries with clients and being too personal. PCA-F requested and was denied by Administrator-A to be C1's PCA while off duty. Administrator-A stated she received a phone call on September 30, 2017 at 6:06 p.m., from house coordinator (HC)-B. C1 fell backwards out of his wheelchair, hit his head, and was sent to the hospital via ambulance. Administrator-A met C1 and his family at the hospital. C1 was on a ventilator and had fluid in his lungs possibly from performing cardiopulmonary resuscitation (CPR). Administrator-A stated she received another phone call from staff and was told both of the anti-tip bars from C1's wheelchair were removed. During her investigation, Adminstrator-A stated PCA-F had removed the anti-tip bars at C1's request in order to fit the wheelchair into C1's car, so C1 could drive himself to the store. Adminstrator-A asked PCA-F to make a late entry note about removing the anti-tip bars and C1 leaving the licensee in C1's record. Administrator-A stated C1 was assigned to PCA-D on September 30, 2017 and PCA-F failed to report C1 was leaving the licensee and that he had removed the anti-tip bars.

During an interview on December 14, 2017, at 3:45 p.m., PCA-C stated when she arrived for her

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0 325	Continued From page 3 shift at 3:00 p.m., C1 was not at the licensee. PCA-D reported both PCA-F and C1 left and did not notify her they were leaving, therefore she did not know when C1 would return. PCA-C stated C1 arrived back to the licensee between 4:15 p.m. and 4:30 p.m. PCA-E assisted C1 out of his car and unfolded his wheelchair. At 5:00 p.m., C1 ate dinner in the dining room and stated he had gone to the store with PCA-F to look for a new television. At 6:00 p.m., C1 requested to get ready for bed and PCA-C stated C1 had a stool in his room next to his bed to help him get into bed (due to his height). PCA-C was fixing C1's bed linen and C1 attempted to get his feet onto the stool, but his left foot got caught underneath. C1 used more force to get his foot up and fell backward in his wheelchair. PCA-C stated as she noticed he was falling, but it all happened too fast. PCA-C stated she saw C1's eyes roll back and blood started coming from his head. PCA-C stated she ran to get PCA-E to help her and PCA-E started CPR while she called the ambulance. PCA-C stated C1's pulse was weak, his lips turned blue, and had shallow breaths. When HC-B arrived, HC-B noticed the anti-tip bars were missing off of C1's wheelchair. PCA-C stated no one had told either her or PCA-E they were removed, and C1 had never requested from her to remove them before. PCA-C stated they were found underneath C1's window next to his television stand. C1's hospital record dated September 30, 2017, indicated C1 was admitted to the intensive care unit for respiratory arrest and anoxic brain injury (no oxygen to the brain). C1 was placed on a supportive measures which included intravenous fluids, antibiotics, was intubated and placed on a ventilator. After no progress of improvement, life support was discontinued and C1 died on	0 325		

Minnesota Department of Health

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0 325	Continued From page 4 October 4, 2017. C1's death record dated 10/4/17, indicated cause of death was anoxic brain injury and respiratory arrest. During an interview on March 12, 2018, at 10:20 a.m., C1's family member (FM)-G stated C1 had his car for about three weeks, but was not sure how often he had drove it around or to the store. The licensee did not have a policy related to removal of device hardware. The licensee did conduct a staff inservice on October 26, 2017, and provided safety device re-training including to monitor equipment before use for proper function and no parts may be removed without management approval. TIME PERIOD OF CORRECTION: 21 days	0 325		

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3430 0000 2379 8570

April 26, 2018

Ms. Chiamaka Enemuoh, Administrator
Lifestone Health Care Inc
319 7th Street
Duluth, MN 55810

RE: Complaint Number HL29862001, HL29862002, HL29862003, and HL29862004

Dear Ms. Enemuoh:

A complaint investigation (#HL29862001, HL29862002, HL29862003, and HL29862004) of the Home Care Provider named above was completed on March 12, 2018, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting 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 statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

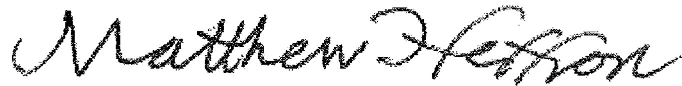
A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879

85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Saint Louis County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Protecting, Maintaining and Improving the Health of All Minnesotans

May 24, 2018

Ms. Chiamaka Enemuoh, Administrator
Lifestone Health Care Inc
319 7th Street
Duluth, MN 55810

RE: Complaint Number HL29862001, HL29862002, HL29862003, & HL29862004

Dear Ms. Enemuoh :

On April 27, 2018 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on March 12, 2018. At this time these correction orders were found corrected.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/tn

Enclosure

cc: Home Health Care Assisted Living File
Saint Louis County Adult Protection
Office of Ombudsman
MN Department of Human Services