Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL30281030M
Compliance #: HL30281031C

Date Concluded: February 24, 2020

Facility Name and Address:
The Waters of Excelsior
723 Water Street
Excelsior, MN 55331
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Carrie Euerle MPH, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An unannounced visit was conducted to investigate 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: Facility staff neglected a client when the client's call pendant was sounding for 5.5 hours and the client was found soiled in feces.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Multiple members of facility staff failed to follow facility policies and procedures regarding checking on clients and responding to call pendants, causing an absence of reasonable care.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the client and client's family were interviewed. Observations made during the onsite visit indicated the facility had implemented new measures to ensure call pendant lights were answered in a timely manner.

The client resided in the specialty care unit of the facility. The client's signed service agreement directed staff to provide medication management, bathing, grooming and homemaking

assistance. The client was able to communicate his needs and had a pendant call light to request for staff assistance as needed.

The day the incident occurred, facility staff found the client in his bed, soiled with feces and the bathroom toilet covered in feces. The client indicated he had not been checked on during the night and had toileted himself without assistance.

Facility call light reports indicated the client pushed his pendant alarm at 2:38 a.m. The call light report further indicated the client's pendant sounded every five minutes until 9:12 a.m., when the nurse noticed on the call pendant monitor screen that the client's pendant had been activated for several hours.

Interviews with administrative staff indicated they completed an internal investigation into the incident and determined night shift staff did not complete every two hour checks on the client, did not wear walkie-talkies during their shift and did not hear the client's pendant alarm. There was not an internal review of the day shift's lack of response to the client's pendant alarm. However, internal investigation documents included questions regarding the functionality of the pendant alarm system, as the day shift stated they did not hear the alarm sounding. A review of the system indicated it was a functioning system at the time of the incident and indicated other call pendants were initiated and cleared during the same time the client's pendant alarm continued to sound.

Interviews with the night shift staff revealed night shift staff did not wear walkie-talkie head sets, however stated they had the walkie-talkies on during the night and could have heard if a pendant alarm sounded. The night shift staff stated they never heard an alarm from a pendant call light during their shift. The staff also stated they did not complete checks on the client because it was not indicated on their service list that the client was to be checked on during the night. One staff member stated she was unaware the client resided in the specialty unit at the time of the incident.

Administrative staff indicated the facility's expectation of staff included that outgoing and oncoming staff completed a check on all clients at the beginning and end of their shift. The night shift staff expectation was to complete every two-hour rounds on all clients unless the client had a signed agreement to not be checked on during the night. Administrative staff further stated the day shift began at 7:00 a.m. the morning of the incident and also did not respond to the client's pendant call light for a period of two hours and twelve minutes, as the pendant alarm was not noticed until 9:12 a.m.

Administrative staff confirmed the client's call light pendant had been alarming for a period of 401 minutes without staff response. Administrative staff indicated they expected all staff to respond timely to pendant call lights and confirmed both the night and day shift did not fulfill this expectation.

In conclusion, neglect was substantiated. Both shifts failed to conduct the scheduled routine rounding. The call pendant either did not function or was not heard, and/or multiple staff members failed to respond to a call pendant, resulting in absence of an essential service.

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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility terminated night shift employees for not following facility policy and procedures. In addition, the facility re-educated all staff, moved the pendant alarm monitor to a more visible area of the facility and added an alert to inform administrative staff if any call light pendant sounded for more than thirty minutes.

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 http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm, 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.

cc:
Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Excelsior City Attorney
Excelsior Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H30281	A. BUILDING: _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS SR LVG MGMT LLC	1600 HOPKINS CROSSROAD MINNETONKA, MN 55305

(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 February 13, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL30281030M & HL30281031C. At the time of the survey, there were 29 clients receiving services under the comprehensive license. The following correction orders are issued for #HL30281031C/HL30281030M, tag identification 0265 and 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).	
0 265 SS=D	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. (a) A person	0 265		

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0 265	Continued From page 1 who receives home care services has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one client (C1) received care and services according to suitable, up-to-date and accepted standards of practice when facility staff failed to answer C1's call light for a period of 401 minutes and C1 was found soiled in feces. This practice 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 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 facility facesheet indicated C1 was admitted to the facility on 1/2/2019 with diagnoses which included weakness, history of falls, osteoarthritis and congestive heart failure. At the time of admission, C1 resided in the independent living	0 265		

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0 265	Continued From page 2 apartments. C1's progress notes indicated C1 moved to the specialty care unit on 9/9/2019 after a hospital admission. C1's progress note indicated C1 required assistance with grooming, bathing and toileting. C1's service agreement dated 9/9/2019 indicated C1 received comprehensive home care services from the facility which included medication management, dressing and grooming assistance, homemaking, bathing twice weekly and CPAP monitoring. C1's service agreement dated 9/9/2019 did not include bathroom assistance. C1's service agreement indicated bathroom assistance was added to the service plan on 9/12/2019. A facility report to the state agency on 9/12/2019 indicated C1 had pushed his call pendant and staff did not respond to the call pendant for a total of 5.5 hours during the overnight shift on the evening of 9/11/2019 going into the day shift of 9/12/2019. C1's progress notes dated 9/12/2019 at 10:41 a.m. indicated the morning nurse noticed the computer monitor flashing that C1's call pendant had been set off at 2:30 a.m. and not been answered by staff. When the nurse went in to C1's room, C1 was sleeping, found soiled in feces, and feces was found all over the toilet and in the bathroom. The progress note further indicated C1 was supposed to have had every two hour checks completed during the night and C1 denied any checks were completed during the night. An email from the Director of Nursing to the	0 265		

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0 265	Continued From page 3 Systems Administrator dated 9/13/2019 at 10:49 a.m. indicated there was an incident related to a call pendant on 9/12/2019 that was pushed by a client and staff did not respond during the night shift. The email further indicated that the morning staff did not hear the auditory page of C1's call light; the DON had concerns regarding this information and inquired into the functionality of the call pendant system. An email in response to the DON dated 9/16/2019 indicated the Systems Administrator ran a full diagnostic review of C1's call pendant from 9/12/2019 which indicated C1's call pendant was pushed at 2:38 a.m. and went off every five minutes and indicated the room number, location and name of the client from 2:38 a.m. to 9:12 a.m. The email further indicates that a full system review was completed and showed at the time C1's pendant was activated, all systems were active and functional. The email indicated that C1's pendant alarm was referenced to C1's room from independent living and not the specialty care unit, however the call alarm was still received by the system and indicated C1's correct location within the specialty care unit. The report further indicated several other lights were activated and responded to during the time C1's call light remained active. An internal investigation report dated 9/18/2019 indicated C1 pushed his call pendant at 2:38 a.m. on 9/12/2019 and the staff (unlicensed personnel-B/ULP-B and unlicensed personnel/ULP-C) during the night shift did not respond to C1's call for assistance. In addition ULP-B and ULP-C did not complete every two hour rounding during the night shift as directed by facility policy. During the internal investigation, ULP-B and ULP-C were interviewed by	0 265		

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0 265	Continued From page 4 administrative and human resources staff. ULP-B and ULP-C indicated they did not wear their headsets that would provide an auditory page of the call pendant and also admitted to not completing every two hour rounding on C1. As a result of the investigation, the facility terminated the employment of ULP-B and ULP-C. In addition, the facility re-educated all staff on the every two hour rounding policy, the call light pendant monitor was moved to a different location to allow for better visibility, and a new alert was added to the call light pendant system that would send an email to administration if a call light pendant was not answered within 30 minutes. An interview with the Director of Nursing (DON) on 2/13/2020 at 12:54 p.m. indicated she completed the internal investigation with the Executive Director and the corporate human resource office. The DON indicated that ULP-B and ULP-C did not wear headsets during their night shift and did not complete rounds on C1 during the night shift. The DON further indicated if ULP-B and ULP-C would have followed policies and procedures, C1 would have been checked on, his call light pendant would have been answered in a timely manner and C1 would have been assisted long before he was found soiled at 9:12 a.m. The DON indicated they had a facility policy of rounding every two hours during the night shift on every resident unless the resident had signed an agreement to not complete two hour checks. This included all clients in the specialty unit despite any assigned services the client may have had scheduled during the night. In addition, the DON indicated they had facility policies and procedures for staff to complete rounding on all specialty care clients at the beginning and end of every shift with the	0 265		

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0 265	Continued From page 5 oncoming and outgoing shifts to complete checks on all specialty care clients. The DON indicated the day shift start time was at 7:00 a.m. and at this time a check should have been completed by the day shift staff. The DON did not know why the day shift did not check on C1 at this time, why C1 was not found earlier by day shift staff or why day shift staff did not respond to the auditory page of C1's call light pendant between the time of 7:00 a.m. and 9:12 a.m. The DON stated the day shift staff did have walkies on and should have heard C1's pendant upon the beginning of their shift. The DON stated she would have also expected the day shift staff to respond more timely to C1's call light pendant and that the day shift staff should also have completed morning rounds at the beginning of their shift and should have responded to C1's call light before 9:12 a.m. During the interview, the DON acknowledged that both the night shift and day shift staff did not complete hourly rounds as expected by facility policy and procedure and did not answer C1's call light pendant within an acceptable time frame. Interview with ULP-B on 2/14/2020 at 10:14 a.m. indicated she did not wear her walkie-talkie head set during the overnight shift on 9/11/2019-9/12/2019, but had it near her so she could hear if a pendant was pushed by a client. ULP-B indicated no call light pendant was set off during the overnight shift. ULP-B further indicated that she and ULP-C completed checks on clients but did not complete a check on C1, as C1 was not included on their service list to complete a safety check or toileting check on during the night. ULP-B was unaware that C1 resided in the specialty care unit or had moved to the specialty care unit and stated that staff did not enter empty rooms during safety checks. ULP-B thought C1's room was empty at the time of the	0 265		

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0 265	Continued From page 6 incident and did not enter the room for rounds and did not hear the pendant light during her shift. Interview with ULP-C on 2/14/2020 at 10:50 a.m. indicated she worked the overnight shift from 9/11/2019-9/12/2019 and was unaware that C1 had services that included toileting during the night shift. ULP-C indicated she and ULP-B completed rounding on clients that had services to be provided during the night, but C1 was not included on that list. ULP-C indicated she could not recall if she wore a walkie-talkie during the night but knows she sat in the office near the walkie-talkies and would have heard if a pendant alarm would have been pushed during the night. ULP-C indicated the monitor for the pendant system was located in another nursing office that was locked during the night so she did not see on a monitor whether a pendant alarm was pushed. Interview with ULP-E and Registered Nurse (RN)-F on 2/13/2020 at 3:35 p.m. indicated that clients should be rounded on every two hours and with every change of shift. ULP-E and RN-F further indicated that not all staff complete this procedure. In addition, ULP-E indicated not all staff wear walkie-talkies during their shift as expected. Interview with the Executive Director (ED) on 2/21/2020 at 12:35 p.m. confirmed she was aware of the incident involving C1 and was involved in the internal investigation into the incident. The ED stated during the interview that she expected staff to answer pendant light calls in a timely manner. The ED stated this was not completed by the night shift staff for C1 for the early morning of 9/12/2019 and that the night shift admitted to not wearing headsets and not completing every two hour rounds on C1 during	0 265		

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0 265	Continued From page 7 that shift. The ED indicated the night shift staff said they were unaware of C1 being a client at that time, but stated this was not true as C1 had a service plan set-up and stated staff was aware he was a client at this time. When questioned about the day shift not responding to C1's call light pendant in over a two hour period, the ED confirmed she expected that the day shift would have responded more timely to C1's pendant. The ED was unaware of any emails from the DON to the IT systems administrator regarding day shift staff not hearing the auditory page for C1's light, but stated that was why IT was questioned on the call light pendant system. A resident assistant (unlicensed personnel/ULP) job description dated July 2017 provided by the facility indicated in the position summary and position responsibility of the ULP included responding immediately to emergency system calls from residents. An undated facility experience document headlining expectations of shift responsibilities included expectations of each shift which indicated to receive shift report from the outgoing shift, answer pendant light pushes in a timely manner and complete system checks of the pendant system. Under the day, evening and night shift expectations including ensuring all clients were checked for safety throughout the shift and the night shift expectations further included completing every two hour checks on the pendant system. Time Period for Correction: Seven days	0 265		

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0 325	Continued From page 8	0 325		
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 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 when facility staff failed to answer C1's call light after a period of 401 minutes and C1 was found soiled with feces. Findings include: On February 13, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility 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. Please refer to the maltreatment public report for details.	