Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL31210001M
Compliance #: HL31210002C

Date Concluded: January 21, 2020

Name, Address, and County of Licensee Investigated:
Legacy Place LLC
302 15th Street Northeast
Sauk Rapids, MN 56379
Benton County

Facility Type: Home Care Provider

Investigator's Name: Jill Hagen, RN, PHN, Special Investigator

Finding: Substantiated, facility and 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: The alleged perpetrator (AP) neglected the client when he failed to report to the registered nurse (RN) an injury following a client's fall and obtain vital signs according to policy.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrator and the facility was responsible for the maltreatment. Although, there is conflicting information about whether the AP neglected to notify the RN of the client's injury, the investigation found the AP neglected to provide the client scheduled safety checks and toileting assistance according to the client's service plan for at least seven hours the night of the client's fall. The facility was aware the AP had a history of not providing cares according to the client's service plan but failed to provide a system to ensure staff completed the client's care.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, observations were made of the licensee's residence, care provided to clients, and staff interactions with clients. The investigation

included a review of the client's record, the AP's personnel file, staff schedules, policies, procedures related to the investigation, and a client interview.

The client received services from the comprehensive home care provider that included safety checks every two hours on the even hour and incontinence care every two hours on the odd hours. The client's diagnoses included dementia. The client was not able to communicate her needs to staff. The client required assistance from staff to ambulate and transfer due to an unsteady gait and poor balance. The client had a history of falls and assessed as a high risk for falls.

Early one morning at approximately 5:00 a.m., the AP notified an on-call nurse he found the client on the floor without injury. The AP's documentation indicated there were drops of blood on the floor and on the back of the client's head. The on-call nurses' documentation indicated the client's vitals were within normal limits; however, did not mention the client bleeding following the fall. Approximately one hour and fifteen minutes later, the day shift unlicensed personnel (ULP) found the client lying in bed with blood in her hair, on the pillow, and the palm of one hand. After cleaning the wound, the ULP found an approximate two centimeter (cm) laceration on the client's scalp and updated the nurse of the client's wound. The client required two staples to close the scalp laceration at a local hospital.

During an interview, the on-call nurse said the AP reported the client slipped out of bed and had no injuries. If he had known of an injury, he would have had the client evaluated at a hospital.

During an interview with the day shift ULP, she stated the AP reported the client fell and was fine with no injuries. During her first safety check between 6:00 a.m. and 6:15 a.m., the ULP stated she found the client with dried and fresh blood to the back of her head.

The facility's investigation indicated staff discovered bloodied wash rags in the laundry.

During an interview, the registered nurse (RN) said after review of the client's fall, the AP failed to notify the on-call nurse of the client's injury following her fall. In addition, the RN viewed a video recorded from the common areas of the residence. The RN stated the video showed the AP did not enter the client's room from 10:00 p.m. until around 5:00 a.m. when the AP found the client on the floor. The AP failed to provide the client with her care planned needs of safety checks and incontinence care. The RN stated services the unlicensed staff provided to clients' were only monitored when concerns were brought to the attention of either her or the housing manager.

The client's service record, indicated the evening shift ULP last completed toileting cares at 7:00 p.m. the evening before, 10 hours before the AP first entered the client's room during his shift.

During an interview, the AP denied not providing safety checks and incontinence care to the client. The AP said he notified the on-call nurse of the client's bleeding following the fall. The AP said he was busy cleaning, doing laundry, and making meals. When asked about the video, the AP made no comment.

In conclusion, neglect was substantiated.

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.

Vulnerable Adult interviewed: No, the client no longer resided at the facility's residence.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided education to the staff regarding importance of following the clients' care planned and assessed needs. The facility suspended the AP's employment during the investigation. The facility no longer employed the AP.

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: 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
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31210	A. BUILDING: _____ B. WING _____	C 01/09/2020

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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 January 9, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL31210002C/#HL31210001M. At the time of the survey, there were # seven clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL31210002C/#HL31210001M, tag identification 0265, 0325, and 0865.	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. 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 number out of compliance are 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 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.	
0 265 SS=G	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. (a) A person who receives home care services has these rights:	0 265		

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0 265	Continued From page 1 (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 document review and interview, the licensee failed to ensure unlicensed personnel (ULP)-A reported an injury to the registered nurse (RN) for one of one clients (C1) reviewed for falls. Unlicensed personnel (ULP)-A found C1 on the floor with blood on the floor and on her scalp. ULP-A failed to report the bleeding to the RN. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). Findings include: Review of C1's assessment dated August 25, 2019, revealed C1's diagnoses included dementia, anxiety, congestive heart failure, osteoarthritis and diabetes. C1 was not able to communicate her needs to staff. C1 required staff assistance to ambulate and transfer with an unsteady balance. The assessment revealed C1 was a high risk for falls with four falls in the	0 265		

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0 265	Continued From page 2 previous three months. Measures to reduce the risk of falls included: appropriate room lighting especially during the night, the primary path in the room should be as straight as possible and free of clutter. Review of C1's Service Plan dated August 25, 2019, revealed C1 required staff assistance for all activities of daily living including incontinence care and safety checks 12 times a day. Review of the licensee's Resident Service Notes (RSN) dated August 26, 2019, revealed at 5:01 a.m. ULP-A documented during his 5:00 a.m. rounds C1 was trying to sit up. ULP-A noticed little blood spots on the floor and at the back of C1's head. ULP-A stated he obtained C1's vital signs, asked C1 if she was ok, and called the on call RN-D. C1 went back to sleep. The note did not indicate if C1 was provided assistance with the bleeding from the back of her head or where C1 was located when she was trying to sit up. ULP-A did not document C1's vital signs. The RSN included a nurse's note by RN-D dated August 26, 2019, at 5:03 a.m. that revealed staff had notified RN-D of C1's fall. The fall was unwitnessed by staff. C1 denied hitting her head or other new pain. Staff was able to get C1 off the floor. C1's vitals signs were within normal limits. RN-D informed staff to continue to monitor C1. The case manager and housing manager were updated. There was no documentation that ULP-A had notified RN-D of the bleeding from C1's head or continued to monitor C1. The RSN included a shift note dated August 26, 2019, at 1:19 p.m. written by ULP-B that revealed C1 received staples in the back of her head due to fall injury. C1 appeared to have bruising and	0 265		

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0 265	Continued From page 3 the area was tender to touch. Review of the licensee's Internal Investigation of Suspected Maltreatment dated August 27, 2019, at 5:43 a.m. completed by RN-C revealed on August 26, 2019, C1 was noted to have drainage from a head injury by the morning staff that was not reported to RN-D. ULP-A failed to complete an incident report for C1's fall and document vital signs. In addition ULP-A failed to call for assistance to lift C1 from the floor according to the licensee's policy. The investigation summary indicated after review, ULP-A did not update the on-call RN, regarding C1's head injury, even though the morning staff found traces blood on the floor where C1 fell. Staff also found bloody rags in the wash. During an interview on January 9, 2019, at 11:16 a.m. the owner/housing manager said one staff was scheduled on the night shifts from 11:00 p.m. to 6:00 a.m. The licensee's residence currently had seven clients and a secured locked house. During an interview on January 9, 2020, at 12:18 p.m. ULP-B said she worked the day shift from 6:00 a.m. to 2:00 p.m. on August 26, 2019. During the change of shift report ULP-A said C2 fell and was fine without injuries. During ULP-B's first safety check around 6:00 a.m. to 6:15 a.m. she observed C1 in bed with her hair darker on top. ULP-B moved C1's head slightly to the side and observed dark and fresh blood in C1's hair, on her pillow, and the palm of a hand. ULP-B contacted the RN who directed ULP-B to attempt to clean the area to locate the area of bleeding. C1 had a cut on the top of her head. The RN directed staff to have C1 taken to a hospital for an evaluation.	0 265		

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0 265	Continued From page 4 During an interview on January 10, 2020, at 8:30 a.m. RN-C said she was contacted by ULP-B the morning of August 26, 2019, and told C1 was found with drainage and a laceration on C1's head. There was a lot of bleeding from the laceration. RN-C contacted C1's primary clinic and arranged for her to be evaluated at a hospital. ULP-B sent a photo of C1's injury to RN-C. The laceration was approximately two centimeters and C1 required two staples to close the wound. Following the investigation of C1's fall, it appeared ULP-A found C1 sitting of the floor against the foot of the bed. ULP-A did not notify RN-D of C1's injury to her head following the fall. After the fall at 5:00 a.m. C1 had been bleeding for about one to one hour and 15 minutes when ULP-B assisted C1. During an interview on January 13, 2020, at 3:15 p.m. RN-D said ULP-A contacted him early the morning of August 26, 2019, about C1's fall. ULP-A indicated C1 slipped out of bed and had no injuries. ULP-A did not notify RN-D of C1's bleeding. Normally with any injury, RN-D would have arranged for C1 to be evaluated at a hospital. During an interview on January 13, 2020, at 3:45 p.m. ULP-A said he was scheduled to work from 10:00 p.m. to 6:00 a.m. the night of August 25, 2019 until the morning of August 26, 2019. ULP-A said when he entered C1`s room around 5:00 a.m. on August 26, 2019. C1 was sitting on the floor. ULP-A said he cleaned up some blood on the floor and saw a small amount of blood in C1's hair. ULP-A said he told RN-D about C1's bleeding but did not look for a source. RN-D told ULP-A to put C1 in bed following the fall. Review of the licensee's Fall Protocol Policy:	0 265		

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0 265	Continued From page 5 What To Do, and not dated, indicated following a fall, staff were to ask the client if they're alright and if they hit their head. Do not move the client if at all possible due to potentially unforeseen injury. Attempt to take vital signs. The RN may advise staff if the client was confused, even if they say they did not hit their head, to feel for bumps and look for bruising on the scalp. Once the client was up and safe take another set of vital signs. Time Period for Correction: Seven (7) days.	0 265		
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 document review and interview, the facility failed to ensure one of one clients (C1) reviewed for falls was free from maltreatment. C1 was neglected when unlicensed personnel (ULP)-A failed to provide incontinence care and safety checks according to C1's assessed and care planned needs. Findings include: On January 21, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and	0 325	No plan of correction is required for tag 325. Please see the public maltreatment report for details.	

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0 325	Continued From page 6 individual staff person were 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		
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when	0 865		

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0 865	Continued From page 7 applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure one of one clients (C1) reviewed received care and services according to their service plan. Unlicensed personnel (ULP)-A did not provide incontinence care and safety checks to C1 according to her assessed needs. As a result, C1 was found on the floor with a head laceration that required staples. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: Findings include: Review of C1's assessment dated August 25, 2019, revealed C1's diagnoses included dementia with behaviors, anxiety, congestive heart failure, osteoarthritis and diabetes. C1 was not able to communicate her needs to staff. C1 required staff assistance to ambulate and transfer with an unsteady balance. C1 was incontinent of her bladder and during the night required staff assistance to check and change her incontinent	0 865		

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0 865	Continued From page 8 product every two hours and prn (as needed). From 11:00 p.m. through 7:00 a.m. staff were to complete safety checks every two hours on the even hours and provide incontinence care every two hours on the odd hours. C1 was unable to use a call light consistently and appropriately due to her significant cognitive deficits. The assessment revealed C1 was a high fall risk with four falls in the previous three months. Measures to reduce the risk of falls included: appropriate room lighting especially during the night, the primary path in the room should be as straight as possible and free of clutter. Review of C1's Service Plan dated August 25, 2019, revealed C1 required staff assistance for all activities of daily living including incontinence care and safety checks 12 times a day. Review of the licensee's Actual Services Delivered form dated August 25, 2019, to August 26, 2019, revealed an ULP provided C1 with toileting assistance at 9:14 p.m. on August 25, 2020. The next entry for a safety check for C1 was document by ULP-A on August 26, 2019, at 4:16 a.m. with toileting assistance at 4:19 a.m. Review of the licensee's Resident Service Notes (RSN) dated August 25, 2019, at 5:00 p.m, revealed an ULP assisted C1 with toileting. At 7:00 p.m. the ULP documented for toileting for C1, under toileting, the ULP documented not applicable (NA). At 11:00 p.m. ULP-A documented under bowels "NC" (no concern). The next entry for toileting assist for C1 was on August 26, 2019, at 1:00 a.m. ULP-A documented "NC". The next entry for activities, was at 5:01 a.m. when ULP-A documented during his 5:00 a.m. toileting C1's room door was locked. ULP-A obtained the key, unlocked the door and	0 865		

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0 865	Continued From page 9 discovered C1 trying to sit up with little blood spots on the floor and at the back of C1's head. ULP-A stated he obtained C1's vital signs, asked C1 if she was ok, and called the on-call registered nurse (RN)-D. C1 went back to sleep. The note did not indicate if C1 was provided assistance with bleeding from the back of her head, whether ULP-A notified RN-D of C1's injury, or where C1 was located when she was trying to sit up. According to the documentation, C1 was not assisted with toileting or had her incontinent product checked from 7:00 p.m on August 25, 2019, until 5:00 a.m. on August 26, 2019 (10 hours). The RSN included a shift note dated August 26, 2019, at 1:19 p.m. written by ULP-B that revealed C1 received staples in the back of her head due to a fall injury. C1 appeared to have bruising and and the area was tender to touch. Review of the licensee's Internal Investigation of Suspected Maltreatment dated August 27, 2019, at 5:43 a.m. completed by RN-C, revealed on August 26, 2019, C1 was noted to have drainage from a head injury by the morning staff that was not reported to RN-D. The investigation summary indicated after review of C1's charting and interviews with staff, it was discovered that ULP-A did not follow C1's careplan or complete her services as written including safety checks and incontinence care every two hours. During an interview on January 10, 2020, at 8:30 a.m. RN-C said she reviewed video footage from the night of the fall. The first time ULP-A checked on C1 was 5:00 a.m. ULP-A failed to carrying out the services for C1 according to the care and service plan. ULP-A jeopardized the safety of C1. There was no approved abbreviation of NC used	0 865		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY PLACE	902 15TH ST NE SAUK RAPIDS, MN 56379

(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
0 865	Continued From page 10 by ULP-A in C1's documentation. RN-C said services provided to clients were monitored only when concerns were brought to the attention of RN-C or the Housing Manager. Review of the licensee's Unlicensed Personnel Job Description dated January 2014, stated this position was responsible for providing personal care and delegated nursing services designed to maintain the clients' physical and emotional well being. The responsibilities and duties included assisting the client with personal cares as identified in the assignment sheet/ client care plan. Observe the client and report to the licensed practical nurse (LPN) or RN changes in the client's physical and emotional condition. Time Period for Correction: Seven (7) days.	0 865		