Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL32320006M
Compliance #: HL32320007C

Date Concluded: December 10, 2019

Name, Address, and County of Licensee Investigated:
St Therese of Woodbury
7555 Bailey Road
Woodbury, MN 55129
Washington County

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
An investigator from 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 a client when the AP failed to follow the client's service plan for toileting, resulting in a fall with injuries.

Investigative Findings and Conclusion:
Neglect is substantiated. The alleged perpetrator (AP) was responsible for neglect. The AP failed to toilet the client during the night shift and the client had a fall with injuries when the client toileted herself. The AP could not sign into the computer to access the client service plan, and therefore did not complete or document any scheduled client services. The AP did not contact the on-call nurse for assistance.

The investigation included interviews with facility staff, including nursing staff, unlicensed staff, and a family member. The investigator conducted observations of staff/ client interactions,

toured the facility, spoke with additional clients, and reviewed documents, including policies related to implementation of service plans, nursing assessments, and falls prevention.

The client lived at the facility for several years due to diagnoses that included traumatic brain injury, abnormalities of gait and mobility, and muscle weakness. The client received services from the home care provider that included bathing assistance, escorts, nursing assessments, housekeeping, laundry, and twice nightly toileting. The client also had a personal care attendant with her continually from 10:00 a.m. to 9:00 p.m. The client used a walker for ambulation due to dizziness and an unsteady gait.

The client's service plan included scheduled toileting every night at 1:00 a.m. and 5:00 a.m. The client had a history of falls due to unsteadiness while attempting to self-transfer to the toilet.

The licensee used an electronic health record and staff obtained information about client specific cares via a hand held electronic device. All staff had a personal log in to the electronic health record.

One night the AP, who had worked for the licensee for several years, picked up a night shift. The AP responded to a call light that indicated the client needed assistance. It was around 5:30 a.m. The AP entered the client's apartment and found her on the floor in the bathroom. The client told the AP she had fallen after going to the bathroom. The AP took the client's vital signs and called the on-call nurse. The AP assisted the client back into bed. The client did not want to go to the hospital, but rather wait for the nurse to come in, which was in about an hour and a half.

The nurse assessed the client when she came in and noted the client had a large bruise on her left arm and her left pinky finger was red and swollen. The client questioned whether the finger was broken. The nurse sent a message to the doctor, taped the client's finger to the next one for support, and put ice on her bruise and finger. The nurse conducted an investigation and found that the AP did not complete toileting for the AP at 1:00 a.m. or 5:00 a.m.

During an interview the AP said that on the night of the incident she attempted to log in to the electronic health record system. The AP said she entered her log in information incorrectly several times and the system locked her out. The AP said there was one other staff in the building during her shift, but she did not attempt to contact anyone to help her log in or retrieve client service information. The AP did not have access to any client service plans or the medication administration records. The AP said that she did laundry for the client's on 2nd and 3rd floors, but did no service tasks. The AP said that she did not toilet the client at 1:00 a.m. or 5:00 a.m. and the client fell trying to get herself to the toilet at 5:30 a.m.

During an interview the nurse said the AP contacted her right after finding the client had fallen. The nurse said she notified the client's guardian and encouraged her to take the client to the hospital to be checked out, but the family member chose not to. The nurse said she reviewed

the services for all the clients present on the night of the incident and the AP had not completed any of the 23 scheduled client service tasks. The nurse said the AP should have called the on-call nurse for assistance if she had difficulty with the electronic health record system.

During interviews several staff said that the client had a history of falls, and although was able to use her call light for assistance, often forgot due to memory issues.

During an interview, a family member said that the client relied on staff to help her because she was unsteady and had no peripheral vision.

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.
(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 licensee coached the AP on the importance of reviewing all clients' services before starting her shift.

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
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32320	A. BUILDING: _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF WOODBURY	7555 BAILEY ROAD SAINT PAUL, MN 55129

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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 November 25, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL32320007C/#HL32320006M. At the time of the survey, there were 59 clients receiving services under the comprehensive license. The following correction order is issued/orders are issued for #HL32320007C/#HL32320006M, tag identification 0325, 0860, 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 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).	
0 325 SS=G	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 facility failed to ensure one of one clients (C1) reviewed was free from maltreatment, when Unlicensed personnel (ULP)-D neglected to toilet C1 at 1:00 a.m. and 5:00 a.m. as directed in the service plan. ULP-D could not sign into the computer to access the client service plan and did not contact the on-call nurse for assistance. C1 got herself up to the toilet and fell. C1 had pain, bruising, and swelling of the left arm and hand. 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: C1's medical record was reviewed. C1 moved into the facility on August 15, 2016 due to diagnoses that included traumatic brain injury, abnormalities of gait and mobility, and muscle weakness. C1's service plan dated March 4, 2019 indicated C1 received home care services	0 325		

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0 325	Continued From page 2 from the licensee that included bathing, escorts, nursing assessments, and twice nightly toileting. C1 also received services of a personal care attendant from an outside agency continually from 10:00 a.m. to 9:00 p.m. every day. C1's task list (documentation of specific tasks staff are to complete for the client) dated March 4, 2019 indicated "reassurance checks at 1:00 a.m. and 5:00 a.m. daily. Please make sure [C1]'s walker is next to her night stand and bed closest to the bathroom when in bed. At 5:00 a.m. if [C1] refuses toileting please tell her that this is her [C1's guardian]'s request and if [C1] does not go you will contact [C1's guardian]." C1's nursing assessment dated March 15, 2019 indicated C1 had a history of a traumatic brain injury with dizziness. The assessment indicated C1 required assistance with transferring and ambulation, due to a history of falls. C1's incident report dated August 22, 2019 at 5:30 a.m. indicated unlicensed personnel (ULP)-D responded to C1's call light and found C1 on the floor in the bathroom. The incident report indicated C1 told ULP-D that she was getting off the toilet and fell. The incident report indicated C1 had injuries to her left arm (swelling and redness), ULP-D took C1's vital signs, and ULP-D contacted the manager on duty (home care clinical director registered nurse (RN)-A). C1 identified a pain level of 4 (on a scale of 0=no pain to 10= worst pain). C1's fall report dated August 23, 2019 at 10:03 a.m. indicated C1 expressed concern that her left pinky finger was fractured. The report indicated RN-A splinted C1's left pinky finger to the next finger with tape and iced C1's bruise. The report	0 325		

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0 325	Continued From page 3 indicated RN-A requested follow up by C1's physician for additional orders. The Point of Care (POC) Documentation Compliance report printed November 25, 2019 at 4:15 p.m. indicated that on the night shift August 21, 2019 (beginning at 10:30 p.m. to August 22, 2019 at 6:30 a.m.) the assisted living clients had 23 scheduled client service tasks. The report indicated zero tasks completed or documented (by ULP-D who was the only staff assigned to the assisted living). During an interview on November 25, 2019 at 3:20 p.m. RN-A stated ULP-D called her on the morning of the incident, as RN-A was on-call. RN-A assessed C1's injury and then looked at the scheduled services provided. RN-A stated that C1's record indicted ULP-D had not documented toileting C1 at 1:00 a.m. or 5:00 a.m. RN-A stated that when she questioned ULP-D about toileting C1, ULP-D said she did not toilet C1 at 1:00 a.m. or 5:00 a.m. During an interview on December 6, 2019 at 12:32 p.m. ULP-D stated that the night of the incident was the first time she worked with C1. ULP-D stated she tried several times to log in to the computer, was locked out, did not see C1's service plan, and so did not know that C1 required toileting at 1:00 a.m. and 5:00 a.m. ULP-D stated she did not call or ask anyone for help with the computer when she could not sign in. ULP-D stated she did laundry for second and third floors for the rest of the night and did not provide any residents with services. ULP-D stated that C1 pressed her pendant for help at 5:30 a.m. and ULP-D found C1 on the floor in her bathroom. ULP-D stated she did vital signs and called the nurse on-call. ULP-D stated RN-A	0 325		

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0 325	Continued From page 4 disciplined her for not checking C1's service plan. The Freedom from Abuse, Neglect, and Exploitation Policy dated November 27, 2018 indicated the licensee maintains an environment where residents are free from neglect. The policy defined neglect as the failure of the licensee, its employees or service providers to provide goods and/or services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 325		
0 860 SS=D	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90	0 860		

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0 860	Continued From page 5 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one clients (C1) reviewed for assessments received timely assessments for one of one clients (C1) revewed for assessments. C1 had a fall and C1's record lacked any nursing assessments for the previous eight months. 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) 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: C1's medical record was reviewed. C1 moved into the facility on August 15, 2016 due to diagnoses that included traumatic brain injury, abnormalities of gait and mobility, and muscle weakness. C1's service plan dated March 4, 2019 indicated C1 received home care services from the licensee that included bathing, escorts, nursing assessments, and twice nightly toileting. C1 also received services of a personal care attendant from an outside agency continually from 10:00 a.m. to 9:00 p.m. every day.	0 860		

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0 860	Continued From page 6 C1's record contained a nursing assessment dated March 15, 2019. C1's record lacked evidence of any additional nursing assessments as of the date of the investigation, November 25, 2019. C1's progress note dated August 14, 2019 at 3:42 p.m. indicated C1 fell in her apartment while walking with her walker from the bathroom. C1 had a bump on her head. C1's progress note dated August 22, 2019 at 9:47 a.m. indicated unlicensed personnel (ULP)-D found C1 on the floor at 5:30 a.m. after a fall in the bathroom. C1 had swelling of her left pinky finger and a bruise on her left lower arm. C1's progress note dated September 8, 2019 at 10:15 a.m. indicated an unlicensed personnel found C1 on the floor in her bedroom. C1's progress note dated September 27, 2019 at 9:39 a.m. indicated an unlicensed personnel found C1 on the floor next to her commode. C1's progress note dated September 30, 2019 at 1:47 p.m. indicted an unlicensed personnel found C1 on the floor next to her commode. C1 had a bruise on her left shoulder. During an interview on November 25, 2019 at 3:20 p.m., home care clinical director registered nurse (RN)-A stated the registered nurse or licensed practical nurse completed nursing assessments at least every 90 days, but also when there was a fall or any change in condition. RN-A did not know why C1 did not have any assessments after March 15, 2019 as C1 resided at the facility continuously since that date.	0 860		

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0 860	Continued From page 7 The Falls Prevention and Reduction policy dated January 1, 2017 indicated that if the registered nurse identifies concerns that the client may be at risk of falls, the registered nurse will do a focused falls assessment and screening. Based on the falls assessment the registered nurse will identify any needed interventions. The Monitoring of Clients and their Services policy dated January 1, 2019 indicated the registered nurse must monitor and reassess each client no less than 90 days from the date of the last visit to determine whether the services are appropriate for the client's needs. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 860		
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	0 865		

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0 865	Continued From page 8 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 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 interview and document review the facility failed to ensure one of one clients (C1) reviewed for service plan implementation, received scheduled overnight toileting assistance as designated in the client service plan. Unlicensed personnel (ULP)-D failed to toilet C1 at 1:00 a.m. and 5:00 a.m. as scheduled and C1 got herself up to the toilet, fell, and had bruising and swelling of the left arm and hand. 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 a 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).	0 865		

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0 865	Continued From page 9 Findings include: C1's medical record was reviewed. C1 moved into the facility on August 15, 2016 due to diagnoses that included traumatic brain injury, abnormalities of gait and mobility, and muscle weakness. C1's service plan dated March 4, 2019 indicated C1 received home care services from the licensee that included bathing, escorts, nursing assessments, and twice nightly toileting. C1 also received services of a personal care attendant from an outside agency continually from 10:00 a.m. to 9:00 p.m. every day. C1's task list (documentation of specific tasks staff are to complete for the client) dated March 4, 2019 indicated "reassurance checks at 1:00 a.m. and 5:00 a.m. daily. Please make sure [C1]'s walker is next to her night stand and bed closest to the bathroom when in bed. At 5:00 a.m. if [C1] refuses toileting please tell her that this is her [C1's guardian]'s request and if [C1] does not go you will contact [C1's guardian]." C1's assessment dated March 15, 2019 indicated C1 had a history of a traumatic brain injury with dizziness. The assessment indicated C1 required assistance with transferring and ambulation. C1's incident report dated August 22, 2019 at 5:30 a.m. indicated unlicensed personnel (ULP)-D found C1 on the floor in the bathroom. The incident report indicated C1 told ULP-D that she was getting off the toilet and fell. The incident report indicated C1 had injuries to her left arm (swelling and redness) and that ULP-D took C1's vital signs and contacted the manager on duty (home care clinical director registered nurse (RN)-A). The report indicated C1 reported a pain	0 865		

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0 865	Continued From page 10 level of 4 (on a scale of 0= no pain to 10= worst pain). C1's fall report dated August 23, 2019 at 10:03 a.m. indicated C1 expressed concern that her left pinky finger was fractured. The report indicated RN-A splinted C1's left pinky finger to the next finger with tape and iced C1's bruise. The report indicated RN-A requested follow up by C1's physician for additional orders. The Point of Care (POC) Documentation Compliance report printed November 25, 2019 at 4:15 p.m. indicated that on the night shift of August 21, 2019 (beginning at 10:30 p.m. to August 22, 2019 at 6:30 a.m.) the assisted living clients had 23 scheduled client service tasks. The report indicated zero tasks completed or documented (by ULP-D who was the only staff assigned to the assisted living). During an interview on November 25, 2019 at 3:20 p.m., RN-A stated she conducted an investigation after C1's fall and C1 had scheduled toileting at 1:00 a.m. and 5:00 a.m. RN-A stated that in the investigation, she discovered that ULP-D did not provide C1 toileting the night of the incident. RN-A stated ULP-D received verbal coaching for not following the service plan. RN-A stated C1 had a large bruise on her left arm and swelling of her left pinky finger. During an interview on December 6, 2019 at 12:32 p.m. ULP-D stated that the night of the incident was the first time she worked with C1. ULP-D stated she tried several times to log in to the computer, was locked out, did not see C1's service plan, and so did not know that C1 required toileting at 1:00 a.m. and 5:00 a.m. ULP-D stated she did not call or ask anyone for	0 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32320	A. BUILDING: _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 865	Continued From page 11 help with the computer when she could not sign in. ULP-D stated she did laundry for second and third floors for the rest of the night and did not provide any residents with services. ULP-D stated that C1 pressed her pendant for help at 5:30 a.m. and ULP-D found C1 on the floor in her bathroom. ULP-D stated she did vital signs and called the nurse on-call. ULP-D stated RN-A disciplined her for not checking C1's service plan. The Nursing Assistant Position Description dated January 2016 indicated the nursing assistant responsibilities included providing direct personal care services for clients according to the client's plan of care. The licensee did not have a policy that addressed the implementation of service plans. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 865		