Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL033832120M
Compliance #: HL033836663C

Date Concluded: March 7, 2024

Name, Address, and County of Licensee Investigated:
Augustana Home Health Care Services
901 4th Avenue North
Minneapolis MN, 55405
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The facility abused four clients (client #1, client #2, client #3, client #4) when they confined them in a secured memory care floor and restricted their independent mobility without identifying safety risk needs for their placement into a secured floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment of client #1, client #2, client #3 and client #4. The facility placed the clients into locked units which restricted their ability to come and go freely. Additionally, the facility provided services under their comprehensive home care licensure and lacked the required licensure for operating the use of the unit and admitting clients into the unit.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers. The investigation

included review of resident records, and employee files. Also, the investigator toured the facility and observed locked units.

Building #1 consisted of four floors. Floors three and four required an electronic “key card” system to exit. Both floors housed twelve clients each. None of the clients on these floors had call pendants to call for staff assistance nor key cards to unlock the exits.

Building #2 consisted of seven floors. Floor seven required an electronic key card system to enter and exit. The exit doors also had “stop signs” placed on them. The seventh floor was inaccessible unless an electronic key card unlocked the elevator. The seventh floor housed seven clients. All seven clients had call pendants. None of the clients had key cards to unlock the exits. At the time of investigator’s observation, the only staff member working on the seventh floor did not have an electronic key card to unlock the elevator or exits.

The facilities provided care under a comprehensive home care provider license, therefore each client received comprehensive home care services in their home.

Client #1 lived in building #1. His diagnoses included high blood pressure, anemia (low hemoglobin), and alcohol abuse. Client #1’s service plan included assistance with housekeeping, laundry, bathing, and medications. He required minimal assistance for dressing and grooming. He required staff to escort him to meals while he used his walker. Client #1’s nursing assessment indicated he was alert and orientated and could communicate his needs. He walked frequently and he did not wander. The nursing assessment indicated the facility would not prohibit him from leaving the memory care unit because he did not have a dementia diagnosis.

During an interview, client #1 said he moved into the facility with his wife who suffered from dementia, but she was no longer at the facility. He said he walks downstairs by himself (when staff let him off the unit) and if he needs assistance, he needs to find a staff member.

Client #2 lived in building #1. Her diagnoses included dementia, depression, and anxiety. Her service plan included assistance with housekeeping, laundry, and medications. She required staff to check on her three times per day. Client #2’s nursing assessment indicated she walked independently. She dressed, toileted, and groomed herself independently. She was alert and orientated but had short term and long-term memory impairment with mild cognitive impairment diagnosis. The assessment indicated client #2 did not wander and she independent with using the call system (although the unit did not have a call system). The assessment indicated she “yells at staff because she does not believe she needs to live in memory care facility.” Client #2’s assessment indicated she has not attempted to leave the building, but attempted to leave the floor and became agitated when staff intervened. There were no conditions impacting communication and she was able to make her needs known. She could use technology independently. Client #2 was also her own decision maker.

During an interview, client #2 said she lived at the facility for ten years and moved from the building "across the street" (the licensee's third operated building). Client #2 said she moved to building #1 because she needed additional assistance, and this was the only apartment available at the time. Client #2 said her apartment was on a secured memory care unit and she felt she did not need to be "locked up." She said, "they don't allow me to leave the floor by myself. They used to let me go by myself, but they don't allow that anymore." Client #2 said she would need to ask employees to escort her off the unit when she wanted to go downstairs.

Client #3 lived in building #1. Her diagnoses included Wernicke's encephalopathy (acute neurological condition caused by thiamine deficiency), chronic pulmonary embolism (blood clots in the lungs), anxiety disorder, and altered mental status. Client #3's service plan included assistance with housekeeping, laundry, medications, dressing, grooming, and bathing. Client #3's nursing assessment indicated she lived in assisted living but received no services. She was alert and orientated but had a diagnosis of altered mental status and made poor decisions. She required supervision when she was off the secured unit. Client #3's assessment indicated she had a history of drug and alcohol use, and the intervention was a secure unit for safety reasons.

Client #3's progress notes indicated she eloped from the facility twice within one month. The notes indicated she left with people she knew but did not return. The facility had a meeting with the client #3's family and the facility attempted to discharge her. The facility provided a notice of termination to client #3 four days after the meeting. The progress notes indicated the facility told the family to obtain an order for client #3 to be in a locked area.

During an interview, a guardian said client #3's family members placed her at the facility. The facility has a locked unit for clients with memory care needs and issues; client #3 does not fit into the situation even though some of her symptoms do. She had a significant alcohol and drug disorder. Her family placed restrictions on her which limited her access to the community, but there was no legal basis for restricting her. The guardian said the court lifted the restrictions and client #3 should be able to come and go as she pleases. The guardian said if she was unable to leave the floor as she chooses, it would be a rights restriction.

Client #4 lived in building #2. His diagnoses included hemiplegia, hemiparesis (weakness and paralysis on one side of the body) from a stroke. Client #4's service plan included assistance with exercising, bathing, dressing, grooming, toileting, laundry, housekeeping, and medications. Client #4's nursing assessment indicated he was alert and orientated. He had weakness of the left side of his body and walked with a cane. Client #4's individual abuse prevention plan indicated he had safety checks for fall risk. Client #4 could follow directions and had no behaviors.

During an interview, client #4 said the facility did not allow him to come and go freely from the unit. He said the facility locked the exits, and he did not have a key card to unlock them.

During an interview, client #4's family member said the client had a progressive disease which would most likely result in further strokes and memory loss. Prior to placement, he lived independently, but suffered a stroke and his left arm and leg was weak. He did not understand his limitations and would be a risk to himself if he was not in a locked unit. The family member said if the client was borderline at the time he entered the locked floor, his medical providers told her he was going to get worse and if he went to a more independent living unit, there was no guarantee he could enter memory care when his health declined. The client did not have a key card to unlock the doors or elevator.

The facility updated their client's service plans during the investigation for clients living in building #1, however their service delivery records did not indicate they received safety checks every two hours prior to the initiation of the investigation. Client #1's record indicated he received no safety checks. Client #2's record indicated she did not receive safety checks every two hours and it was unclear if she received any safety checks up until approximately three weeks prior to the investigation. Client #3's record indicated she received safety checks four times daily as opposed to every two hours, while being in a locked memory care unit, without the use of a call pendant.

During an interview, a manager for building #2 said there was always one caregiver working on the seventh floor, but the other floors in the building had one caregiver assigned to work between two floors because they required less services.

During an interview, a nurse from building #2 said staff have keycards to get into the memory care units, however agency staff do not have keycards to get in or out, therefore another staff member must let them in or out.

During an interview, a manager for building # 1 said he tells family members to obtain an order from the physician to admit a client into memory care. The manager said when the client admits into the memory care unit, the nurse completes a nursing assessment which should support the client's need to be in a locked memory care unit.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Vulnerable Adult interviewed: Yes. Client #1, #2, #3, #4
Family/Responsible Party interviewed: Yes. Client #1, #3, #4. Client #2, not applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility began re-assessing their client's needs and updated their service plans. The facility ordered call pendants for their memory care clients.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H03383	A. BUILDING: _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HOME HEALTH CARE SERVICES	901 4TH AVENUE NORTH MINNEAPOLIS, MN 55405

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a complaint investigation. 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: #HL033832120M On February 5, 2024, February 6, 2024, February 15, 2024 and February 16, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders is issued. At the time of the complaint investigation, there were 148 clients receiving services under the provider's Comprehensive Home Care Provider license. The following correction order is issued. The following correction order is issued for #HL033832120M, tag identification 325.	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	144A.44, Subd. 1(a)(14) Free From Maltreatment be free from physical and verbal abuse, neglect,	0 325		

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0 325	Continued From page 1 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: The facility failed to ensure four of thirty-one clients, (C4, C8, C23, C25) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	0 325	No plan of correction is required for this tag.	