Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356254261M
Compliance #: HL356254991C

Date Concluded: November 5, 2024

Name, Address, and County of Licensee Investigated:
Care Partners Homecare LLC
5908 79th Avenue
Brooklyn Park, Minnesota 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Not Substantiated

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 alleged perpetrator (AP) neglected the resident when the AP did not call 911 after the resident became unresponsive.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP failed to call 911 immediately, the error was an isolated incident. The resident admitted to the hospital, received antibiotics, and returned to their baseline health condition. The resident discharged from the hospital enrolled on hospice, but due a pre-existing health condition, not due to the inaction of the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's case worker. The investigation included review of the resident record, death record,

hospital records, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral palsy. The resident's service plan included assistance with transfers, toileting, and safety checks twice daily. The resident's assessment indicated the resident required total assistance with cares from staff.

A progress note in the resident's medical record indicated the resident went to the emergency department (ED) due to decreased level of consciousness, low blood pressure of 88/56, elevated pulse of 112, and low oxygen saturation of 76 to 88 percent on room air. The AP, an unlicensed personnel (ULP), contacted the registered nurse (RN) due to the resident remaining in bed and not taking his medication. The RN requested the AP obtain vitals, and the RN would come to the facility. Less than five minutes later, the AP called again to report an outside agency staff person was at the facility and recommended the resident be sent to the hospital. The resident had a history of recurrent pneumonia and had been to the hospital multiple times. Hospice had been discussed with the resident and the resident's power of attorney (POA) previously due to ongoing changes in the resident's health status.

The ambulance run report indicated emergency medical services (EMS) arrived at the facility and found the resident unconscious and gasping for air at a labored breathing rate. The resident had a strong pulse but a critically low oxygen saturation of 37 percent.

Hospital records indicated the resident arrived at the ED unresponsive with oxygen saturations of 88 to 90 percent with assisted ventilation. The ED staff intubated the resident and transferred him to the intensive care unit (ICU). The resident remained in the hospital for about two weeks receiving treatment before returning to the facility. The resident's hospital diagnoses included acute respiratory failure and pneumonia which caused sepsis (a life-threatening condition in which the body improperly responds to an infection). Additionally, the resident had a history of aspiration pneumonia, including two hospital admissions within two months prior to this incident. The records indicated the resident's recent throat cancer and subsequent radiation likely played a role in his recurrent aspiration events. Speech pathology notes indicated the resident had a severe swallowing impairment. A video swallow study revealed silent aspiration (inhaling food or liquid into the airway without noticing). Discharge paperwork indicated the resident enrolled onto hospice due to recurrent aspiration pneumonia.

The resident's hospice records indicated the resident had end stage lung disease with recurrent aspiration pneumonia.

The resident's treatment record indicated the resident received turning and repositioning every two hours and as needed. The record indicated staff completed this task six times between midnight and when the resident left for the hospital.

The facility monitored the resident's temperature, oxygen saturation, respirations, and blood pressure every one to two days. During the two months leading up to the incident, documented oxygen saturations ranged from 89 to 100 percent. Two days prior to the incident, the resident's oxygen saturation was 89 percent.

During an interview, an occupational therapist (OT) stated she had worked with the resident off and on for about a year. She arrived at the facility and waited for a few minutes while the AP helped the resident. The AP stated the resident was ready, so she went in to see the resident. The OT found the resident nearly unresponsive. His eyes were closed, so she patted him, but he did not respond. The OT thought she would have to start cardiopulmonary resuscitation (CPR), as he had very shallow respirations, to the point she almost thought he was not breathing. The OT asked the AP if everything was okay. The AP stated no, but he had a call into the RN. The OT told the AP he could not wait for the RN and to call 911. The AP followed her instructions and had to guide him on what to do, but she had to tell the dispatcher everything.

During an interview, the RN, who was also the licensed assisted living director (LALD), stated he received notification from the AP the resident had become lethargic and did not want to get up. The resident had still been responsive at that point. A short time after giving the AP instruction, he received a second call from the AP stating the outside agency staff person thought the resident needed to go to the hospital. The resident had just recently returned from the hospital and had recurring pneumonia. The facility did not have orders for checking vitals, but they did check them multiple times per month, as well as if something changed. Normally, when the resident started to decline, they would see an increase in behaviors. That would indicate to staff something was about to change with his health. However, this time, he didn't have any behaviors prior. During the resident's hospitalization, they had a meeting with the care team and discussed a tracheostomy, palliative care, and hospice. The resident could not swallow his secretions and kept getting pneumonia. The resident wanted to be able to eat and might not be able to do that with a tracheostomy. The resident's POA helped make the decision to enroll the resident on hospice.

During an interview, the AP stated the resident had not been up for the morning as usual when he started his shift. He spoke with the overnight ULP who reported the resident had a good night but stayed up later than usual, so he might have been catching up on sleep. The AP went to talk with him and asked if he wanted to get up, but he declined. The AP left to care for other residents. When the AP went back to check on him, the resident had not been responding as before. The AP notified the nurse, took a set of vitals, and raised the head of the bed a little. Again, the AP left to care for other residents before returning to the resident. Then, an outside agency staff person arrived at the facility to work with the resident. The AP finished working with the resident and noticed he did not seem to be responding as usual. The outside agency staff person went into the room, then called for the AP. The AP stated he contacted an RN who was on his way to the facility, but the agency staff person requested he call 911. The AP listened and called 911, then gave the phone to the agency staff person who provided 911 with more

information on the resident’s condition. The AP stated the day before this incident, the resident had been up in his chair in the living room, talking about going to the store.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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 resident is deceased.
Family/Responsible Party interviewed: No. Attempted but unable to contact.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided services. The AP contacted the RN to update on a change in condition. The AP followed the direction of the OT.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35625	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	5908 79TH AVENUE BROOKLYN CENTER, MN 55443

(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 On September 24, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL356254991C/#HL356254261M. No correction orders are issued.	0 000		