Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20004008M
Compliance #: HL20004009C

Date Concluded: May 19, 2021

Name, Address, and County of Licensee Investigated:
Ingleside
2811 Roland Avenue
Fairmont, MN 56031
Martin County

Facility Type: Home Care Provider

Investigator's Name:
Erin Johnson-Crosby, RN, Special Investigator

Finding: Substantiated, facility 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 facility failed to provide supervision for client #1 when client #2 pushed client #1, which caused client #1 to fall. Client #1 sustained a hip fracture, was hospitalized, and later died.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected client #1 when the facility failed to keep client #1 safe from client #2. The facility was also responsible for neglecting client #2 when the facility failed to provide appropriate supervision, did not reassess, or provide on-going interventions to address client #2's behaviors. The facility staff were aware of client #2's on-going, physically abusive behaviors towards other clients in the memory care unit but failed to implement appropriate protective measures for those clients.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. Client #1 and client #2's family members were also interviewed. The investigation included an onsite visit to the facility for observations of the memory care unit, review of medical records and facility policies and procedures.

Client #1's diagnoses included dementia, chronic urinary tract infections and heart failure. Client #1's medical record indicated she resided in memory care and required assistance with activities of daily living (ADLs) but was independent with mobility. Client #1's assessments indicated she was at risk for abuse due to her dementia and would not be able to report abuse or neglect.

Client #2's diagnoses included dementia and hypertension. Client #2's medical record indicated she resided in memory care and required assistance with ADLs but was independent with mobility. Client #2's service plan included behavior management three times daily. Client #2's medical record indicated she was at risk for abusing other vulnerable adults; staff were instructed to monitor and intervene with any abusive episodes. Client #2's behavior chart-indicated facility staff were instructed to address client #2's abusive behaviors with the intervention of offering snacks, redirection, and to lock the memory care hallway door and other clients' doors (if clients were in their rooms).

Two months prior to the incident with client #1, client #2's progress notes indicated she had an increase in her abusive behaviors. The nurse practitioner adjusted her medications, and facility staff updated her service plan due to ineffective interventions.

Approximately three weeks before the incident with client #1, client #2's behavior chart indicated client #2 yelled at another client and pushed an unknown client. Shortly after, staff observed client #2 being aggressive with the same unknown client. The behavior chart indicated the unknown client was unable to defend herself. There was no documentation that facility staff member who observed this create an incident report or documented the incident in the client's progress notes.

On the morning of the incident with client #1, client #2's behavior chart indicated facility staff observed client #2 yelling and being disruptive during a locked de-escalation attempt on her hallway. Client #2 walked down the hallway and banged her walker on client room doors. The client room doors and memory care hallway remained locked for over an hour. A facility incident report indicated at approximately 7:40 p.m., a staff member heard client #2 yelling, "This is what happens when you do not listen to me! You listen to me now!" The report indicated after hearing a scream, the staff member found client #1 on the floor with client #2 on top of her. The staff member observed client #2 pushing her walker into client #1's leg. Emergency Medical Services (EMS) later transported client #1 to the hospital where she was admitted.

Client #1's hospital records indicated client #1 was pushed down by another client. She reported pain in her right hip and was not able to walk. Client #1 required surgical repair for a fractured hip. Client #1 spent ten (10) days in the hospital before she was transferred to a long-term care

facility. Client #1's death certificate indicated Client #1 passed away approximately one month after the incident with client #2. The cause of death was severe caloric malnutrition and failure to thrive.

Two days after the incident with client #1, client #2's behavior charting indicated client #2 again displayed aggressive and abusive behavior towards staff and clients by banging her walker on doors, ramming her walker into staff, and attempting to trip a client. Facility staff intervened by locking client #2 down her hallway and ensuring all client doors were locked.

Four days after the incident with client #1, client #2's behavior charting indicated facility staff observed client #2 arguing with clients and staff and attempting to hit them with her walker. It was noted the staff had to physically guard and block the other clients from client #2 as client #2 would go after the other clients and try to punch them. At one point, client #2 hit an unknown client, but that client told staff they were fine. There was no documentation of an incident report or follow-up regarding the client #2's behaviors that day. Client #2's medical record did not include any information that client #2 had hit other clients.

The same day (four days after the incident with client #2), client #1's progress notes indicated client #1's family member called the facility with concerns about client #2 continuing to reside in the facility (memory care) with other vulnerable adults. It was noted the RN then contacted another assisted living facility to inquire about alternative placement.

Fifteen (15) days after the incident with client #1, client #2's progress notes indicated client #2 was discharged to another facility.

When interviewed, client #1's family member said if her mom had not been pushed, she would still be alive. The family member said she did not believe the facility was equipped to handle someone with behavioral issues (like client #2). The family member said she contacted the facility after the incident to try to ensure this did not happen to other clients.

When interviewed, several staff members said client #2 had an increase in her aggressive behaviors for about six months. Staff members said client #2 had hit other clients before hitting client #1. Staff members said there were no new interventions put in place to address client #2's behaviors after client #2 pushed client #1, and the facility provided no training after this incident.

When interviewed, the registered nurse (RN) said client #2 had attempted to hit another client before the incident with client #1. The RN said the immediate intervention implemented to ensure client safety was to check a urinalysis on client #2. The RN also said client #2's individual abuse prevention plan and service plan were not updated after the incident with client #1. The RN said she remembered talking with management about client #2 not being appropriate for this setting (the assisted living facility) before the incident with client #1, but nothing was documented. The RN also said she was responsible for completing the internal investigation. She stated she did not talk to the other two staff members on-duty the evening of the incident.

When interviewed, the nurse practitioner (NP) said the goal is to keep everyone safe, but that could be difficult in memory care. The NP said she was not aware the facility locked client #2 in the hallway when she was agitated.

In conclusion, neglect against the facility 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.

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: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility: Client #1 was discharged to another facility after the hospital stay. Client #2 was discharged from the facility fifteen (15) days after the incident.

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.

cc:

The Office of Ombudsman for Long-Term Care
County Attorney for Martin County
City Attorney for Fairmont, MN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20004	A. BUILDING: _____ B. WING _____	C 04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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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, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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 April 28, 2021, the Minnesota Department of Health initiated a complaint investigation for complaints #HL20004008M/HL20004009C and HL20004011M/HL20004012C. At the time of the investigation, there were 47 clients being served under the comprehensive license. The following correction orders were issued for #HL20004008M/HL20004009C: 0325, 0790 and 0810. Correction orders were also issued for HL20004011M/HL20004012C: 0265, 0325, 0825, 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).	
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1.Statement of rights. (a) A client who	0 265		

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0 265	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G 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 record review, the licensee failed to provide services according to accepted standards of medical, nursing, and health care practices for falls for one of three clients (C3) reviewed. C3 fell 13 times between November 19, 2020. and April 17, 2021. Nursing staff failed to conduct an assessment to determine causative factors and implement appropriate interventions to minimize the risk of future falls and potential injury following C3's falls. 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: The American Journal of Nursing article titled, "When a Fall Occurs," dated November 2007, volume 107, number 11, indicated fall analysis	0 265		

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0 265	Continued From page 2 should be completed to identify to the underlying causes and risk factors of the fall. Immediate follow-up will help identify and enable staff to initiate preventative measures. C3 was admitted to the licensee's memory care on September 4, 2019, with diagnoses, which included dementia, diabetes Type 2, muscle weakness, abnormalities of gait and mobility. C3's service plan dated January 1, 2021, indicated C3 resided in memory care and required assistance with activities of daily living (ADLs), medication administration, behavior management, safety checks, toileting, and transfers. C3's service plan was not signed. C3's nursing assessment dated March 19, 2021, indicated C3 had dementia, was alert to person only (not place or time), and was at-risk for falls. C3 required the assistance of one staff member for transfers and ambulation, but self-transferred numerous times per day. C3's care plan dated April 26, 2021, indicated C3 was disoriented daily. C3 had impaired judgement and scored 4 out of 10 on a Mental Status Questionnaire (MSQ) which indicated C3 had moderate memory loss. C3 scored a nine (9) on the SLUMS (examination for detecting cognitive impairment), which indicated C3 had dementia. C3's care plan also indicated C3 may not be a reliable reporter due to his dementia. C3's care plan, last reviewed September 19, 2020, indicated C3 was not safe with transfers and ambulation with use of the walker, required assistance of one staff member, and did not call for assistance. C3's listed care plan interventions included: encourage non-skid footwear, decrease	0 265		

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0 265	Continued From page 3 clutter, and keep items within reach. An intervention added to the care plan on May 4, 2020, identified staff should place C3 in the day room during the day to prevent falls. C3's incident reports identified C3 experienced falls on the following dates: " On November 19, 2020 at 12:53 a.m., C3 was self-transferring and did not have a chair sensor on his recliner. While trying to get to his wheelchair, he fell. Licensee staff reminded C3 to use his pendant to call for help and add a chair sensor. " On November 22, 2020 at 1:42 a.m., licensee staff found C3 sitting on the edge of the bed; no alarms were on. He stated he slid off the bed to the floor. Licensee staff reminded C3 to use his pendant to call for assistance and keep his shoes on. " On November 24, 2020, at 10:06 p.m., licensee staff found C3 sitting on the floor next to his recliner and wheelchair. He said his foot got caught while he was trying to self-transfer. Licensee staff reminded C3 to use his pendant to call for help and wait for staff to assist him. " On November 29, 2020, at 5:45 a.m., C3 said he slid out of his chair and did not have his shoes on. Licensee staff reminded C3 he needs to put his shoes on before he stands up and to call for assistance. " On December 13, 2020, at 4:05 a.m., licensee staff found C3 on the floor in from of his recliner and yelling for help. Licensee staff reminded C3 to use his pendant to call staff to help him transfer before he transfers so he does	0 265		

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0 265	Continued From page 4 not fall. " On December 15, 2020, at 5:13 a.m., while adjusting himself in his wheelchair, C3 fell out of the wheelchair; no alarms were on. When licensee staff found him, C3 had one shoe on and one shoe off. Licensee staff reminded C3 to use his pendant so that staff can assist him, and that he needed to put both shoes on. " On December 21, 2020, at 11:15 p.m., licensee staff found C3 on the floor in front of his toilet without shoes on. Licensee staff reminded C3 to wear shoes and call for help before getting up. " On December 27, 2020, at 10:13 p.m., licensee staff found C3 on the floor next to his recliner. Licensee staff reminded C3 that he needs to use his pendant to call for assistance, wait for staff to help, and put his shoes on. " On February 6, 2021, at 1:00 a.m., licensee staff found C3 d on the bathroom floor in front of his toilet. Licensee staff reminded C3 that he has a pendant on, he should use it, and staff were available to assist him. " On February 22, 2021, at 12:40 a.m., licensee staff found C3 on the floor in the bathroom; he had his pendant around his neck, but he did not use it. C3 forgot to put his shoes on. Licensee staff reminded C3 to use his pendant to call for help and to make sure he had gripper socks or shoes on. C3's wheelchair was switched out so the brakes could be checked. " On February 24, 2021, at 7:18 p.m., licensee staff found C3 on the floor. He was self-transferring and did not have shoes on.	0 265		

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0 265	Continued From page 5 Licensee staff reminded C3 to push his pendant before he transfers so staff can assist him and that he should wear shoes. " On March 12, 2021, at 7:45 a.m., licensee staff found C3 by the recliner on the floor; C3 said he slipped out of the chair and did not have shoes on. Licensee staff reminded C3 he needed shoes on when he transferred. " On April 17, 2021, at 4:45 p.m., licensee staff found C3 on the floor next to his wheelchair; he did not know how he fell. Licensee staff reminded C3 to wait for staff assistance and that he was being checked for a urinary tract infection. C3 was admitted to the hospital on April 18, 2021, with a diagnosis of sepsis. C3 had ten (10) falls from November 19, 2020, through April 17, 2021, that occurred after 10:00 p.m. and before 7:00 a.m. During an interview on May 5, 2021, at 12:30 p.m., unlicensed personnel (ULP)-C said C3 would not be able to remember if staff reminded him to do something, and he did not remember to use his call light. During an interview on May 7, 2021, at 12:30 a.m., ULP- E said no one had ever asked for her input regarding C3's falls. ULP-E said there had not been any new fall interventions for C3 recently, and C3's current interventions consisted of reminding him to put on his shoes or use his pendant. ULP-E said C3 will not remember if you remind him to do things. During an interview on May 10, 2021, at 10:00 a.m., ULP-G said nursing staff never asked for her input regarding C3's falls. ULP-G said C3	0 265		

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0 265	Continued From page 6 sometimes will remember to do the things when staff remind him. During an interview on May 11, 2021, at 10:00 a.m., registered nurse (RN)-K said C3 would sometimes remember interventions for safety. RN-K said on April 13, 2021, C3's toileting was changed to hourly, but hourly toileting was not listed in C3's incident report, progress notes or service plan. RN-K said client falls are discussed at the licensee's quality meeting where they (nursing/management) go over each client's falls, but nothing is written down for tracking and trending falls. RN-K said she questioned staff about incidents if an incident report is not filled out correctly. During an interview on May 11, 2021, at 1:00 p.m., the Housing Director said she was not aware that tracking and trending of falls should be documented. The Housing Director said nursing/management talk about the falls in "stand up" and at monthly quality meetings; if there are trends, RN-K said the trends are talked about. During an interview on May 21, 2021, at 8:14 a.m., the nurse practitioner (NP)-P said she would expect the licensee staff to implement appropriate interventions to prevent falls from reoccurring. Review of the licensee's quality meeting minutes dated January, February, March, and April 2021 indicated how many client falls occurred each month at the licensee, but there was no documentation of tracking or trending of falls for specific clients. Licensees' policy titled, Falls Prevention and Reduction, dated January 1, 2021, indicated the	0 265		

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0 265	Continued From page 7 RN will identify a client's risk for falls. Based on the fall assessment, the RN will identify any needed interventions and will educate the resident and staff. The RN will make recommendations about actions the staff should assist with or remind the resident about to reduce the risk of falls. No further information was provided. TIME PERIOD TO CORRECTION: Seven (7) days	0 265		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) 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 interviews and document review, the facility failed to ensure three of three clients (C1, C2, C3) were free from maltreatment. C1, C2, and C3 were neglected by the facility. Findings include: On April 28, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred. The MDH concluded there was a	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325.	

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0 325	Continued From page 8 preponderance of evidence that maltreatment occurred, and the facility was responsible for the maltreatment.	0 325		
0 790 SS=F	144A.479, Subd. 3 Quality Management Subd. 3.Quality management. The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activities to evaluate the quality of care and determine whether changes in services or other procedures needed to be made to ensure safe and competent services to clients. The licensee's quality management activities did not address appropriate interventions or changes in services or procedures to address C2's aggressive behaviors with staff and clients, locking C2 in the hallway, or locking other clients in their rooms to protect them from C2. This had the potential to affect all clients and staff in memory care.	0 790		

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0 790	Continued From page 9 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C2's behavior documentation dated December 22, 2020, identified after supper C2 yelled at an unknown client and pushed them away. Staff redirected C2 and let her calm down. Later on, licensee staff saw C2 being aggressive to the same unknown client. The other client could not defend herself. Staff directed C2 to Hallway 2 and shut the door. C2's behavior documentation on January 11, 2021, at 12:50 p.m., identified C2 yelled at staff and was loud and disruptive during a de-escalation attempt while C2 was locked in Hallway 2. C2 continued to bang her walker up against doors and yell for over an hour. All clients that were in their rooms during this time had their doors locked so C2 could not get in their rooms. C2's behavior documentation on January 11, 2021, at 9:16 p.m., identified at 7:40 p.m., staff heard C2 yell from Hallway 2, "This is what happens when you don't listen to me! You listen to me now! See you will get it when you do not listen!" Staff then heard a scream and found C1 on the floor with C2 was on top of her pushing C1's walker into C1's leg. C1 kept saying "I didn't deserve to be pushed! I didn't do anything wrong!	0 790		

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	H20004	A. BUILDING: _____ B. WING _____	C 04/28/2021

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0 790	Continued From page 10 I'm sorry!" Licensee staff sent C1 to the emergency department (ED) and required surgery for a fractured hip. Licensee's internal investigation notes dated January 11, 2021, identified unlicensed personnel (ULP)-C contacted the registered nurse (RN)-K and told her she heard C2 yell, "This is what happens when you don't listen to me! You listen to me now! See you will get it when you don't listen!" ULP-C stated she heard a scream and ran down the hall to find C1 on the floor with C2 on top of C1 pushing the walker into C1's leg. Staff brought C2 to her room. The internal investigation notes indicated staff called an ambulance and transferred C1 to the ED. RN-K contacted the ED and was notified C1 fractured her hip and required surgical intervention. The internal investigation notes also identified C2 had not been acting any differently on the prior shift or earlier in the shift at the time of the incident with C1. C2's behavior documentation on January 13, 2021, at 12:58 p.m., identified from 6:15 a.m. until 8:00 a.m. staff observed C2 banging on client apartment doors with her walker in Hallway 2. It was noted staff locked all doors in the hallway. Staff observed C2 ramming her walker into staff and attempting to scratch them. She also attempted to trip another client. C2's behavior documentation on January 15, 2021, at 9:54 p.m. identified C2 came out of her room and started arguing with other clients and staff. Staff observed C2 physically charge at clients and staff and hit them with her walker. It was noted staff had to guard and block the other clients because C2 would go after them for no reason and try to punch them. C2 did hit another	0 790		

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0 790	Continued From page 11 client, but the client told staff they were fine. It was noted C2 punched, scratched, and pinched staff. Licensee's Quality Council Meeting Minutes dated January 19, 2021, identified the licensee completed a Minnesota Adult Abuse Reporting Center (MAARC) report about C1 being pushed down by C2, which occurred eight days prior to the meeting. The minutes did not contain any information regarding how the licensee kept other clients safe since the incident nor did the minutes address any of C2's behaviors. The minutes did not reflect if the attendees addressed the intervention of locking C2 in the hallway or locking other clients in their rooms if C2 was aggressive. Licensee's Quality Management Plan dated January 19, 2021, identified the Housing Director will develop a continuous quality improvement and management program to maintain continuous performance improvement consistent with current professional standards and the highest quality services for our residents. The purpose of the plan is to review resident services, complaints, and to evaluate if any change in service, staffing or other applicable procedures may need to be made. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 790		
0 810 SS=D	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for	0 810		

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0 810	Continued From page 12 each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) for one of four clients (C2) reviewed. C2 pushed C1 causing C1 to fall and fracture her hip. The licensee failed to update C2's IAPP to identify C2's risk for abusing other clients; no interventions were added to C2's IAPP to address C2's this vulnerability. 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: C2's medical record was reviewed. C2's medical diagnoses included dementia, hypertension and history of a stroke. C2's signed service plan dated October 1, 2020, indicated C2 required assistance with morning and evening cares,	0 810		

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0 810	Continued From page 13 bathing, homemaking, medication administration, reminders for meals, behavioral interventions three times per day and safety checks five times per day. C2's assessment dated October 1, 2020, identified C2 was at risk to abuse other vulnerable adults. C2 would tell other clients what they should be doing and would disagree and argue with them. Staff were instructed to monitor for these episodes and reassure C2 staff would take care of the other clients. If C2 was not able to be re-directed, staff would escort C2 to a quiet area to calm down or escort the other clients to safety. C2's behavior documentation instructions initiated on May 6, 2019, identified nursing staff should document if C2 displays any behavior requiring staff interaction or intervention. Interventions included: Offer C2 food, tell C2 her car is in the shop getting an oil change, contain C2 on her hall by shutting the hallway door so she goes into her room and de-escalates. It was noted if any clients are in their rooms on the hallway, staff were instructed to lock client doors and check on clients every 15 minutes for safety checks. C2's 90-day assessment dated November 2, 2020, identified C2 required assistance with dressing, bathing, and meal reminders. C2 was independent with walking with a two-wheeled walker. C2 was assessed as at-risk to abuse other vulnerable adults. It was noted C2 tells other clients what they need to do and not do; C2 will disagree with them and begin to argue. The identified interventions included facility staff will monitor for these episodes and reassure C2 that staff will take care of the other clients, and she does not need to worry. If was noted that if staff	0 810		

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0 810	Continued From page 14 are unable to redirect C2, staff will escort C2 to a quiet area to calm down or escort the other client(s) to safety. C2's behavior documentation on December 22, 2020, identified C2 yelled at other clients and pushed them away. Staff redirected C2 and let her calm down. Staff later observed C2 displaying the same aggressive behaviors with the same client. The other client could not defend herself. It was noted staff redirected C2 to Hallway 2 and shut the door. C2's behavior documentation on January 11, 2021, at 12:50 p.m., identified C2 was loud, disruptive, and yelling. It was noted staff locked C2 in Hallway 2, and C2 continued to yell and bang her walker up against doors. All client doors were locked. C2 remained locked in Hallway 2 for approximately one and half hours. C2's behavior documentation on January 11, 2021, at 9:16 p.m., identified at 7:40 p.m., staff heard C2 yell from Hallway 2, "This is what happens when you don't listen to me! You listen to me now! See you will get it when you do not listen!" Staff then heard a scream and found C1 on the floor with C2 was on top of her pushing C1's walker into C1's leg. C1 kept saying, "I didn't deserve to be pushed! I didn't do anything wrong! I'm sorry!" Staff sent C1 to the emergency department (ED); C1 required surgery for a fractured hip. Licensee's internal investigation notes dated January 11, 2021, identified the registered nurse (RN)-K was called by ULP-C. ULP-C heard C2 yell, "This is what happens when you don't listen to me! You listen to me now! See you will get it when you don't listen!" ULP-C heard a sharp	0 810		

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0 810	Continued From page 15 scream, ran down the hall, and found C1 on the floor with C2 was on top of C1 pushing the walker into C1's leg. C2 was brought to her room. Staff called an ambulance, and C1 was transferred to an ED. RN-K contacted the ED and was notified C1 had a fractured hip requiring surgical intervention. The internal investigation notes also identified C2 had not behaved any differently on the prior shift or earlier in the shift. C2's service plan and IAPP were not updated with new interventions after C2 pushed C1. C2's progress notes on January 11, 2021, did not include any documentation of the incident between C1 and C2. C2's behavior documentation on January 13, 2021, at 12:58 p.m. identified from 6:15 a.m. until 8:00 a.m., C2 banged on client doors with her walker in Hallway 2. It was noted staff locked all client doors on the hallway while C2 continued scratching at and ramming her walker into staff. C2 also tried to trip a client. C2's behavior documentation on January 15, 2021, at 9:54 p.m. identified C2 started arguing with clients and staff. C2 then charge and hit them with her walker. It was noted staff had to guard and block the other clients because C2 would go after them for no reason and try to punch them. C2 hit another client, but the client said they were fine. C2 punched, scratched, and pinched staff. During an interview on May 11, 2021, at 10:00 a.m., RN-K said C2 had attempted to hit another client prior to the incident between C2 and C1 on January 11, 2021. RN-K said she should have updated C2's IAPP after this incident.	0 810		

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0 810	Continued From page 16 Licensee's policy titled, Initial and On-Going Nursing Assessment of Clients, dated March 16, 2018, identified an assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults. The RN will use this assessment as the basis for the resident's IAPP that identified the specific measures to be taken to minimize the risk of maltreatment to the client or to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
0 825 SS=D	144A.4791, Subd. 1 HBOR Notification to Client Subdivision 1.Home care bill of rights; notification to client. (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 before the date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand. (b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices. "If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health.	0 825		

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0 825	Continued From page 17 You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement should include the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint. (c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement that the Home Care Bill of Rights (BOR) was provided to one of one client (C3) reviewed. C3's most recent BOR was not signed or dated by C3 or C3's representative. 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	0 825		

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0 825	Continued From page 18 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: C3 was admitted to licensee's memory care on September 4, 2019, with diagnoses that included dementia, diabetes Type 2, and muscle weakness. C3's power of attorney (POA) documents dated March 28, 2014, indicated family member (FM)-O listed as C3's health care and financial POA . C3's nursing assessment on March 19, 2021, indicated C3 had dementia and was oriented to person only. C3's record review revealed the most recent BOR included in C3's record was not signed or dated by C3 or C3's representative. During an interview on May 11, 2021, at 1:00 p.m., the Housing Director said C3's admission paperwork was not signed. She said she had talked to FM-O multiple times, but she wanted her lawyer to review it before she signed it. During an interview on May 12, 2021, at 5:15 p.m., FM-O said when C3 was admitted to the licensee, the only thing she signed was an application for admission. FM-O stated she was contacted three times on April 29, 2021, by the Housing Director stating she needed to sign papers. FM-O said the Housing Director came to	0 825		

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0 825	Continued From page 19 her workplace on April 30, 2021, at approximately 9:15 a.m., to have her sign these papers. FM-O told the Housing Director she would have her lawyer look at them before signing them. FM-O reported she had not been contacted by the licensee before April 29, 2021, to sign these documents. Review of email correpondence dated May 13, 2021, sent by FM-O about the documents given to her by the Housing Director on April 30, 2021, identified documents were pre-dated and had stickers placed where FM-O should sign. The documents included an unsigned BOR that was dated September 4, 2021. Licensee's policy titled, Home Care Bill of Rights, dated March 29, 2018, indicated the Housing Director reviews the Home Care Bill of Rights with each new resident and the resident's representative. When the review is complete, the Housing Director asks the resident and/or the resident's representative to sign an acknowledgement that she/he has received a copy and documents this in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 825		
0 865 SS=D	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 date that home care services are first provided, a home care provider shall finalize a current written service plan.	0 865		

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0 865	Continued From page 20 (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 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 record review, the licensee failed to ensure the client service plan included a signature or other authentication by the client or the client's representative for one of three clients (C3) reviewed. C3's service plans dated November 4, 2019, January 1, 2020, and January 1, 2021, were not signed by C3 or C3's representative. 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	0 865		

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0 865	Continued From page 21 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: C3 was admitted on September 4, 2019, to memory care with diagnoses which included dementia, diabetes Type 2, and muscle weakness. C3's power of attorney (POA) documents dated March 28, 2014, indicated family member (FM)-O was listed as C3's health care and financial POA. C3's service plans dated November 4, 2019, and January 1, 2020, were not signed by the C3 or C3's representative. C3's nursing assessment on March 19, 2021, indicated C3 had dementia, and was oriented to person only. C3's service plan dated January 1, 2021, identified C3 resided in memory care and required assistance with activities of daily living (ADLs), medication administration, behavior management, safety checks and transfers. C3's January 1, 2021, service plan was not signed. C3's progress notes did not include any information regarding why the aforementioned service plans were not signed. During an interview on May 11, 2021, at 1:00 p.m., the Housing Director said C3's last service plan was not signed. She said she had talked to FM-O multiple times, but FM-O wanted her	0 865		

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0 865	Continued From page 22 lawyer to review it before she signed it. During an interview on May 12, 2021, at 5:15 p.m., FM-O said she was contacted three times on April 29, 2021, by the Housing Director stating she needed to sign papers. FM-O said the Housing Director came to her workplace on April 30, 2021, at approximately 9:15 a.m., to have her sign these papers. FM-O told the Housing Director she would have her lawyer look at them before signing them. FM-O reported she had not been contacted by the licensee before April 29, 2021, to sign these documents. Review of email correspondence sent on May 17, 2021, from FM-O to the investigator contained copies that were given to FM-O by the Housing Director that were pre-dated and had stickers placed where FM-O should sign. The documents included: 1) Service Plan dated November 4, 2019, that was printed on April 29, 2021. 2) Service Plan dated January 1, 2020, that was printed on April 29, 2021. 3) Service Plan dated January 1, 2021, that was printed on April 29, 2021. Licensee's Content of Home Care Services Agreement dated March 16, 2018, identified home care services agreement/plan and fee schedule of the agreed upon services with the client and/or the client's representative. The home care services agreement is signed by the Housing Director and by the client and/or the client's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20004	A. BUILDING: _____ B. WING _____	C 04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(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