Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20533033M
Compliance #: HL20533034C

Date Concluded: August 18, 2020

Name, Address, and County of Licensee Investigated:
Whispering Pine Assisted Living
830 West Main Street
Anoka, MN 55303
Anoka County

Name, Address, and County of Housing with Services location:
The Lake Cottage
18660 Simonet Drive NW
Elk River, 55330
Sherburne County

Facility Type: Home Care Provider

Investigator's Name: Jane Aandal, RN, Special Investigator

Finding: Substantiated, facility 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 facility nursing staff neglected to complete a significant change comprehensive reassessment after the client returned from an emergency room visit. The client told staff she was planning her suicide and was found deceased four days later.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected to assess the client after a change in condition when the client told the facility she had a plan to commit suicide, was sent to the emergency room, and returned from an emergency room visit for suicidal ideation. The client was found deceased four days later. The facility did not have a process/procedure to comprehensively assess a client's change in mental health.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The

investigation included a review of the client's medical record, emergency room record, police reports, and policies and procedures.

The client's diagnoses included, but were not limited to major depressive disorder, post-traumatic stress disorder (PTSD), and, chronic fatigue syndrome (unknown cause with symptoms of aching, depression, and prolonged tiredness. The client placed notes on her room door instructing staff members not to wake her. The client generally woke up later morning and took her medications at that time.

One morning, at approximately 10:00 a.m., the client approached a staff member and asked her to clean the community bathroom, which had been used by another client. The staff member was busy warming up breakfast food for a client and passing medications. The staff member offered the client to use one of the other two community bathrooms and she declined. The staff member then cleaned the toilet, and knocked on the client's door to let her know it was clean. The client went to use the bathroom. The client told the staff member there was water on the bathroom floor and it needed to be cleaned. The client insisted on using that bathroom. The staff member returned to the bathroom with a mop and bucket, and the bathroom door was half closed. The client slammed the staff member's right foot and knee with the bathroom door. It was unable to be determined if this was an accident or an intentional act. The staff member screamed and cried due to the pain. The staff member called the on call nurse to report the incident. The client went outside and called the police to report the incident.

Review of the police report indicated at 10:16 a.m., the client called the police. Both parties agreed the conversation started over a cleaning request. The client stated the staff member started yelling at her first. A client overheard both the client and the staff member yelling at each other and did not know who started it. The client was advised to communicate with management about her employee concerns.

At approximately 1:15 p.m., a staff nurse stopped at the facility. The client requested to talk to the staff nurse. The client was very upset and crying about the incident with the staff member. The client told the staff nurse she was planning her suicide. The client had texted a message to her son to say she loved him. The staff nurse called the registered nurse, called 911, and the client agreed to go to the emergency room. The client returned to the facility at approximately 7:00 p.m., that same evening.

Review of the emergency room record indicated the client's diagnosis of passive suicidal ideation. The client was sent back to the facility with a safety plan, which included phone numbers for family members, crisis phone numbers, and the suicide hotline number. If unable to follow the safety plan, call 911.

An interview was conducted with the staff nurse. The staff nurse stated the client reported to her that she had a suicide plan. The staff nurse stated the client was in tears due to the incident between her and the other staff member. The staff nurse stated she had never heard the client

make suicidal statements or indicate she had a plan. The staff nurse stated she considered the suicidal plan a significant change in the client's condition. The staff nurse also stated there should have been an intervention added.

An interview was conducted with the registered nurse. The registered nurse stated the suicidal plan was not a significant change in the client's condition. The registered nurse stated the client had no documentation in her record of suicidal ideation. The registered stated the client did not have a change in her behavior. The registered nurse stated for example if a client had an infection and there was a change in their mentation a full assessment would be done. The registered nurse stated the client did not have provider orders for any of the medications used in her suicide.

Review of the death record indicated the cause of death was toxic effects of multiple drugs (hydrocodone, oxycodone, duloxetine, and gabapentin).

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: Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken

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: Health Regulation Division – Home Care and Assisted Living Program
The Office of Ombudsman for Long-Term Care
Anoka County Attorney
Elk River City Attorney
Elk River Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20533	A. BUILDING: _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSTD LIVING	830 WEST MAIN STREET ANOKA, MN 55303

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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 August 4, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL20533034C/#HL20533033M. At the time of the survey, there were four clients receiving services under the comprehensive license. The following correction orders are issued for #HL20533034C/#HL20533033M, tag identification 0860, 0875, 0880, 1080, and 2155.	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	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	0 325		

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0 325	Continued From page 1 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 one of one client reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On August 4, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) is required. Refer to the maltreatment public report for details.	
0 860 SS=J	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 the date that home care services	0 860		

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0 860	Continued From page 2 are first provided. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after the date that home care services are first provided. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 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 interviews and document review, the licensee failed to complete a comprehensive nursing reassessment of the client's mental health needs and services for one of one client (C1) reviewed, when C1 stated she was planning her own suicide. The licensee sent C1 to the emergency room for an evaluation; however, a nursing reassessment was never completed upon her return. C1 was found deceased four days later. This practice resulted in a level four violation (a violation that results in 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's	0 860		

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0 860	Continued From page 3 diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder (PTSD), and chronic fatigue syndrome (CFS, an unknown cause with symptoms of aching, depression, and prolonged tiredness). C1's service agreement dated March 12, 2020, indicated the client received assistance with medication management dressing, grooming, and bathing. C1's care plan dated March 12, 2020, indicated C1 was ambulatory. C1's psychiatric nurse practitioner (PNP) documented a virtual visit on June 8, 2020. The documentation indicated C1 was having difficulty sleeping, was tearful, and was unable to talk to people without feeling sick. Engaging in conversation was draining, and C1 was struggling with how she could live like this. C1 indicated she did not want to die by suicide like her mother. Chronic conditions included, PTSD, CFS, insomnia, and depression with anxiety. C1 was receiving psychotropic medications (medications to treat mental illness) and would benefit greatly from therapy. Would like to establish with psychiatry and will order referral. C1' nursing progress note dated June 27, 2020, indicated the nurse on call received a call from staff. C1 had been verbally abusive towards the staff for not cleaning the bathroom at the time she told her to do so. Staff stated that she had been busy with other things and when she finally had the time to clean it, client got angry and jammed her foot with the bathroom door. The client was heard screaming at staff over the phone. Staff also reported pain to the foot and not being able to complete her shift due to the pain.	0 860		

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0 860	Continued From page 4 Review of the police report dated June 27, 2020, at 10:16 a.m., indicated C1 called the police. Both parties agreed the conversation started over a cleaning request. C1 stated ULP-H started yelling at her first. A client overheard both C1 and ULP-H yelling at each other and did not know who started it. C1 was advised to communicate with management about her employee concerns. Licensed practical nurse (LPN)-D documented a late entry in C1's nursing progress notes on June 29, 2020, for June 27, 2020. The progress note read, "Client told me that she was planning her own suicide. She stated that she texted her son letting him know how much she loved him if anything should happen to her. Client stated that she felt hopless [sic]. Client agreed to go into the hospital. 911 called and client was transported to [name of hospital]. She was released later that evening with no knew [sic] orders or follow ups." C1's emergency room documentation dated June 27, 2020, indicated C1 was diagnosed with passive suicidal ideation. C1 was sent back to the facility, at approximately 7:00 p.m. C1 was given a safety plan which included phone numbers for family members, crisis phone numbers, and the suicide hotline number. If unable to follow the safety plan, call 911. Registered nurse (RN)-A documented in C1's nursing progress note on July 1, 2020. The progress note read, "At approximately 1:15 p.m., I received a call from [staff name] who was scheduled at the [location] for a 7-3 shift July 1, 2020. She stated that [client name] had not been out of her room and wanted to notify me. I replied that we should let her be, she does not want us to wake her up. At 3:24 p.m., [staff name] called me	0 860		

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0 860	Continued From page 5 from the [location] and stated that [client name] was not moving and her mouth was open. She wasn't breathing and she couldn't wake her her. I told her to call 911 right away. I left the office and went to the house, upon arrival she was pronounced dead and an active investigation was under way. I provided the weekly medication boxes and all of her medications. They took pictures of all of her pill bottles and her box. Copies were made of her ER form, June medications sheets and July medication sheets and given to the investigator. Her case manager [name] was notified at 4:41 p.m." During an interview on August 6, 2020, at 10:40 a.m., RN-A stated she completed the admission paperwork for C1. RN-D stated she received a phone call from LPN-D on June 27, 2020, that C1 was suicidal and had a plan. RN-A stated she was surprised C1 was not admitted to the hospital. RN-A stated ULP-H should have called the on call nurse to report C1 had returned from the emergency room that same evening. RN-A stated there was no nursing assessment completed after C1 returned from the emergency room visit. RN-A stated the suicidal plan was not a significant change in condition for C1. RN-A stated she did not think anything else needed to be added since the emergency room "cleared" C1. RN-A stated C1 did not have provider orders or prescriptions for any of the medications used in her suicide. RN-A stated upon admission they did not go through the client's personal possessions; however, they changed their policy after the suicide. During an interview on August 13, 2020, at 2:02 p.m., RN-A stated on June 29, 2020, LPN-D called to let her know that C1 was back in the building. RN-A stated LPN-D spoke with C1 and	0 860		

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0 860	Continued From page 6 she was at her baseline. RN-A stated C1 had no documentation in her record of suicidal ideation. RN-A stated C1 did not have a change in her behavior. RN-A stated for example if a client had an infection and there was a change in their mentation a full assessment would be done. RN-A stated C1 did not have provider orders for any of the medications used in her suicide. During an interview on August 10, 2020, at 1:13 p.m., LPN-D stated she worked at the house where C1 lived. LPN-D stated she would hear C1 crying fairly often in her room. LPN-D stated often C1 did not want to talk. LPN-D stated C1 did not feel people could understand her CFS diagnosis, and spent most of her time in her room. LPN-D stated C1 had a note on her door to not awaken her and she would take her medications when she woke up. LPN-D stated C1 had put notes up around the house telling staff not to have conversations at the nursing desk which was right across from her room. LPN-D stated on Saturday, June 27, 2020, she was not working. She stated she stopped at the house to drop something off and C1 wanted to speak with her. LPN-D stated C1 was in tears due to the incident between her and unlicensed personnel (ULP)-H that morning. LPN-D stated she called 911 and notified RN-A that C1 had made the suicidal statement. LPN-D stated C1 did see a psychiatric nurse practitioner. LPN-D stated she did not know until Tuesday June 30, 2020, that C1 had returned the same evening from the emergency room. LPN-D stated she called RN-A to let her know that C1 was back in the building. LPN-D stated she had never heard C1 make suicidal statements or indicate she had a plan. LPN-D stated she would have considered the suicidal plan a significant change in C1's condition. LPN-D stated she felt there should have been an intervention added.	0 860		

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0 860	Continued From page 7 During an interview on August 11, 2020, at 1:05 p.m., ULP-H stated she worked on June 27, 2020, from 7:00 a.m., until 11:00 p.m. ULP-H stated on June 27, 2020, at approximately 10:30 a.m., C1 asked ULP-H to clean the communal bathroom for her to use. ULP-H told C1 she was making breakfast for another client and passing medications. ULP-H then went and cleaned the bathroom for C1 to use. ULP-H also offered C1 to use one of the other two bathrooms that were available. ULP-H then knocked on C1's door and told her the bathroom was clean and ready to use. C1 went into the bathroom and then told ULP-H she needed to mop the bathroom floor. ULP-H told C1 the floor was not dirty and she would clean it in the afternoon. C1 insisted so ULP-H went to get a mop and bucket. When ULP-H returned C1 was in the bathroom and she then jammed ULP-H's right leg and foot in the door. ULP-H stated she screamed and started to cry as her right foot hurt. ULP-H stated she called the on call nurse and C1 went outside and called the police. ULP-H stated later in the day C1 went to the hospital and the hospital did not call to let her know that C1 was returning that evening. ULP-H stated when C1 returned she was supposed to call the on call nurse to let her know. ULP-H stated she did not work for the next two days. ULP-H stated she returned to work on June 30, 2020 and worked the evening shift. ULP-H stated that evening C1 went around the house and removed signs that she had put up. There was no reassessment after C1's significant change in her mental condition. C1 stated she had a suicide plan and there were no additional interventions or services put in place to minimize the risk for suicide. C1 was oriented to person, place, and situation.	0 860		

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0 860	Continued From page 8 C1's death record dated July 1, 2020, indicated the cause of death was toxic effects of multiple drugs (hydrocodone, (a narcotic medication), oxycodone, (an opioid medication) duloxetine, (an antidepressant medication) and gabapentin (a nerve pain medication). The licensee's Assessment-Schedules policy dated February 7, 2020, indicated the nurses would conduct assessments, monitoring and reassessments consistent with Comprehensive Home Care Requirements and the individualized needs of each home care client. TIME PERIOD FOR CORRECTION: Seven (7) days	0 860		
0 875 SS=F	144A.4791, Subd. 10 Termination of Service Plan Subd. 10.Termination of service plan. (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information: (1) the effective date of termination; (2) the reason for termination; (3) a list of known licensed home care providers in the client's immediate geographic area; (4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home	0 875		

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0 875	Continued From page 9 care bill of rights, section 144A.44, subdivision 1, clause (17); (5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and (6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment. (b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide a written notice of termination of services which included the required content for one of one client (C1) reviewed. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). Findings include:	0 875		

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WHISPERING PINES ASSTD LIVING	830 WEST MAIN STREET ANOKA, MN 55303

(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
0 875	Continued From page 10 C1's medical record was reviewed. C1's diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder (PTSD), and chronic fatigue syndrome (CFS, an unknown cause with symptoms of aching, depression, and prolonged tiredness). C1's service agreement dated March 12, 2020, indicated the client received assistance with medication management dressing, grooming, and bathing. C1's 30 day notice was dated June 29, 2020, with an order to vacate the property no later than July 29, 2020. The termination reason listed by the licensee was that they were not able to meet C1's demands and expectations. During an interview on August 13, 2020, at 2:02 p.m., registered nurse (RN)-A verified C1 was not given a list of known licensed home care providers in her geographic area. RN-A stated she knew that was a requirement and had just updated the policy. The licensee's Termination of Agreement policy dated March 12, 2020, indicated upon 30 days written notice by either party, and when client's behavior conduct, personal hygiene or unruliness is interfering with the facility and/or the well-being of other clients. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	0 875		
0 880 SS=F	144A.4791, Subd. 11 Client Complaint and Investigative Process	0 880		

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0 880	Continued From page 11 Subd. 11.Client complaint and investigative process. (a) The home care provider must have a written policy and system for receiving, investigating, reporting, and attempting to resolve complaints from its clients or clients' representatives. The policy should clearly identify the process by which clients may file a complaint or concern about home care services and an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints. A home care provider must have a process in place to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights. This complaint system must provide reasonable accommodations for any special needs of the client or client's representative if requested. (b) The home care provider must document the complaint, name of the client, investigation, and resolution of each complaint filed. The home care provider must maintain a record of all activities regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review. (c) The required complaint system must provide for written notice to each client or client's representative that includes: (1) the client's right to complain to the home care	0 880		

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0 880	Continued From page 12 provider about the services received; (2) the name or title of the person or persons with the home care provider to contact with complaints; (3) the method of submitting a complaint to the home care provider; and (4) a statement that the provider is prohibited against retaliation according to paragraph (d). (d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to investigate written complaints and document a resolution for each complaint made by one of one client (C1) with record reviewed. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). Findings include: C1's medical record was reviewed. C1's diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress	0 880		

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0 880	Continued From page 13 disorder (PTSD), and chronic fatigue syndrome (CFS, an unknown cause with symptoms of aching, depression, and prolonged tiredness). On May 14, 2020, C1 sent an email to registered nurse (RN)-A with many complaints listed. The email was also sent to licensed practical nurse (LPN)-D, the licensee's vice president, and the Minnesota Department of Health's Office of Health Facility Complaints. One of the complaints identified an unlicensed personnel (ULP)-J who C1 stated was rude, curt, and crabby. C1 stated ULP-J was very mean, mentally abusive, neglectful at times, and used silence as a punishment which affected her mental health in a negative way. C1 stated it's very difficult to be in the same house as her because of her poor attitude and toxic energy create poor morale here. During an interview on August 6, 2020, at 10:40 a.m., RN-A stated C1 did not like ULP-J. RN-A stated C1 had issues with ULP-J being "bossy." During an interview on August 13, 2020, at 2:02 p.m. RN-A stated the complaint was not a "formal" complaint. RN-A stated a formal complaint would be one she received in the office. RN-A stated since she started January 22, 2020, there had not been any complaints. When the investigator explained to RN-A that an email in writing was a formal complaint, she agreed she did receive the email from C1. RN-A stated C1 had a lot of complaints and she took them "with a grain of salt." RN-A verified she had no documentation of resolution to C1's complaints. RN-A stated she called ULP-J and told her C1's concerns. RN-A stated she moved ULP-J to work in another house with more supervision. RN-A had no documentation in ULP-J's personnel file	0 880		

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0 880	Continued From page 14 regarding the complaints filed against her from C1. The licensee's Complaints Regarding Home Care policy dated February 7, 2020, indicated Whispering Pine Assisted Living desires to promptly and appropriately respond to all complaints from clients, client representative, family members, and staff regarding the provision of home care services. The policy indicated written complaints would be addressed by RN-A. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 880		
01080 SS=C	144A.4794, Subd. 3 Contents of Client Record Subd. 3.Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any;	01080		

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01080	Continued From page 15 (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights; (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status.	01080		

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01080	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the client record included documentation of significant changes in the client's status for one of one client (C1) with record reviewed. C1 called the police after a verbal disagreement with unlicensed personnel (ULP)-H. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). Findings include: C1's medical record was reviewed. C1's diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder (PTSD), and chronic fatigue syndrome (CFS, an unknown cause with symptoms of aching, depression, and prolonged tiredness). C1's service agreement dated March 12, 2020, indicated the client received assistance with medication management dressing, grooming, and bathing. C1' nursing progress note dated June 27, 2020, indicated the nurse on call received a call from staff. C1 had been verbally abusive towards the staff for not cleaning the bathroom at the time she told her to do so. Staff stated that she had been busy with other things and when she finally had	01080		

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01080	Continued From page 17 the time to clean it, client got angry and jammed her foot with the bathroom door. The client was heard screaming at staff over the phone. Staff also reported pain to the foot and not being able to complete her shift due to the pain. Review of the police report dated June 27, 2020, at 10:16 a.m., indicated C1 called the police. Both parties agreed the conversation started over a cleaning request. C1 stated ULP-H started yelling at her first. A client overheard both C1 and ULP-H yelling at each other and did not know who started it. C1 was advised to communicate with management about her employee concerns. During an interview on August 11, 2020, at 1:05 p.m., ULP-H stated she worked on June 27, 2020, from 7:00 a.m., until 11:00 p.m. ULP-H stated on June 27, 2020, at approximately 10:30 a.m., C1 asked ULP-H to clean the communal bathroom for her to use. ULP-H told C1 she was making breakfast for another client and passing medications. ULP-H then went and cleaned the bathroom for C1 to use. ULP-H also offered C1 to use one of the other two bathrooms that were available. ULP-H then knocked on C1's door and told her the bathroom was clean and ready to use. C1 went into the bathroom and then told ULP-H she needed to mop the bathroom floor. ULP-H told C1 the floor was not dirty and she would clean it in the afternoon. C1 insisted so ULP-H went to get a mop and bucket. When ULP-H returned C1 was in the bathroom and she then jammed ULP-H's right leg and foot in the door. ULP-H stated she screamed and started to cry as her right foot hurt. ULP-H stated she called the on call nurse and C1 went outside and called the police. During an interview on August 13, 2020, at 2:02	01080		

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01080	Continued From page 18 p.m., registered nurse (RN)-D, stated normally when an incident occurred staff would fill out an incident report. RN-D stated she thought ULP-H wrote something down; however, there was no documentation of C1 calling the police. RN-D stated she should have followed up on the incident. The licensee's Client Record - Outline policy dated February 7, 2020, indicated documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01080		
02155 SS=C	626.557, Subd. 14 Abuse Prevention Plans Subd. 14.Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1)	02155		

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02155	Continued From page 19 the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the abuse prevention plan included the required content for one of one client (C1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has	02155		

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02155	Continued From page 20 potential to affect a large portion or all of the clients). Findings include: C1's medical record was reviewed. C1's diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder (PTSD), and chronic fatigue syndrome (CFS, an unknown cause with symptoms of aching, depression, and prolonged tiredness). C1's vulnerability assessment/abuse prevention plan dated March 11, 2020, lacked an assessment of C1's susceptibility for abuse by other individuals including other vulnerable adults. During an interview on August 13, 2020, at 2:02 p.m., registered nurse (RN)-A stated she documented C1 was able to report abuse or neglect and verified C1's susceptibility to abuse was not addressed. The licensee's policy Vulnerable Adults and Maltreatment, Communication, Prevention, and Reporting dated February 10, 2020, indicated individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measure to minimize maltreatment based on identified information. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02155		