MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Gondola Group Inc.	HL24603010	August 16, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
4307 159th Court West	10:00 a.m. - 4:15 p.m.	October 18, 2016
Facility City:	**Investigator's Name and Title:**	
Rosemount	Rhylee Gilb, RN Special Investigator	

State:	ZIP:	County:
Minnesota	55068	Dakota

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when s/he had a fall in the shower and sustained several vertebrae fractures.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect is substantiated. The home care provider staff left a client unattended in the shower, and the client fell and experienced cervical fractures.

The client was admitted to the home care provider with diagnoses that included dementia, syncope with collapse, and cerebral ischemia (lack of oxygen to the brain). The client had a known history of fainting related to heart problems. The client's nursing assessment indicated the client required assistance of one person for transfers, ambulation, and showering.

The facility policy required staff members providing showers to remain in the bathroom during the shower, if the client was a full assist. The staff were required to review each client's service plan. The service plans were accessible to staff.

The day of the incident, the client was sitting on a shower chair in a bath tub with a raised edge. The client requested to wash his/her own body and hair. The staff member handed the client a wash cloth, then left the client unattended in the shower. The staff member stated s/he left to go into the client's room, which was located across the hallway from the bathroom, to gather clothes. The client got out of the shower unassisted, began to dry her/himself, and fell. When the staff member heard a loud noise and entered the bathroom, s/he saw the client lying on the floor bleeding from the back of the head. The staff member pressed a towel to the head wound, called 911, and sent the client to the hospital. The staff member also notified the registered nurse and the client's family.

At the hospital, the client was found to have neck fractures and was treated with surgery, and required pins for stability and a neck brace. The client returned to the home care provider after his/her hospitalization. The client required daily pin care, and the brace restricted head and upper body movement. Three months later, the pins were removed and the client remained in a hard neck brace.

During an interview, the client stated s/he was often left alone during showers. S/he stated staff usually helped him/her onto the shower chair, turned on the water, and then would leave to gather his/her things. On the day of the incident, the client stated s/he remembers falling head first, but then could not remember anything else until s/he was at the hospital.

During staff interviews, a nurse stated s/he told staff not to leave clients alone in the shower and to only provide showers when two staff members were in the facility, but s/he also said s/he was aware that some staff were providing showers to clients when there was only one staff member on duty.

During an interview, the client's family member stated the injuries from the fall had been difficult on the client. The family member explained that while the client was in the neck brace with pins, s/he had to lay in one position and was uncomfortable for three months. Since the client was unable to get up unassisted, the family member stated s/he provided the client with a bell to alert staff of his/her needs. The client has had to be in a hard neck brace for another three months and a soft brace for an additional three months.

During an interview, the alleged perpetrator (AP) stated the client liked doing tasks independently and often asked to wash his/her own hair and body. S/he stated usually the client would wait in the shower until staff could assist the client out. The AP stated s/he knew s/he was supposed to stay with the client, but was not aware, at the time of the incident, of the client's fall risk and history of fainting.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The client fell while left unattended in the shower. The individual staff member knew the client required assistance in the shower, and was not asked by the client to leave the bathroom. The individual was trained by nursing staff to stay with the client during showers. The showering policy indicated gathering supplies was to be done prior to showering, and if the client requires full assist, staff must not leave the client unattended. However, the facility was not enforcing the expectation to remain in the room while clients were showering.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is

substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: four

Were residents selected based on the allegation(s)? ○ Yes ◉ No ○ N/A

Specify: all vulnerable adults

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews:memory impairments

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: seven

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

- [x] Medication Pass
- [x] Cleanliness
- [x] Transfers
- [x] Meals
- [x] Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Rosemount Police Department

Dakota County Attorney

Rosemount City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H24603	A. BUILDING: _____ B. WING _____	C 09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On 8/16/16, a complaint investigation was initiated to investigate complaint #24603010 . At the time of the survey, there were 6 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to ensure safety for one of five clients (C1) reviewed, when a client who required assistance was left alone in the shower, fell, and experienced a cervical fracture. 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 licensee policy titled "Policy and Procedure on Showering/Bathing Residents" dated 9/14/16, indicated supplies were to be gathered prior to starting the shower, and if the client was a full assist, staff must not leave the resident unattended. C1's medical record was reviewed. C1 was admitted with diagnoses that included dementia, syncope and collapse, and cerebral ischemia. C1's service plan dated 7/30/15 indicated the client required assistance with bathing twice a week. An incident report dated 3/5/16 indicated C1 fell	0 325		

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0 325	Continued From page 2 while in the shower at 6:50 a.m. Unlicensed personnel (ULP)-G completed the incident report and indicated C1 was in the shower and ULP-G was outside of the bathroom in the medication closet. ULP-G heard C1 fall and yell. ULP-G immediately went into the bathroom and found C1 on the floor, bleeding from the back of her head. ULP-G held a towel to the back of C1's head, called 911 and stayed with C1 until paramedics arrived. C1 was admitted to the hospital. C1's hospital report dated 3/5/16 through 3/9/16 indicated C1 experienced cervical fractures. C1 required a halo cast with pins for stability of the fractures. C1 was discharged on hospice back to the licensee. During an on-site investigation on 8/16/16, the bathroom where C1 had fallen was observed. The bathroom is located across the hallway from C1's room. The bathroom is narrow, approximately a nine foot by five foot space. The bathtub is tub/shower combo with a raised edge. Inside the tub is a shower chair. Across from the tub is the toilet with a raised toilet seat that has metal handle bars. Directly to the right of the toilet is a wood vanity. That day C1 was observed wearing a hard cervical collar. C1 required assistance of one staff member and walker for ambulation. C1 spent the majority of her time resting in a recliner in the living room. C1 did ambulate with staff to the dining room for meals. No call light system or a way for clients to alert staff was observed throughout the licensee. During an interview on 8/16/16 at 1:40 p.m., registered nurse (RN)-C stated the unlicensed personnel should be with clients during a shower at all times and they are trained for that. RN-C stated showers are usually completed when two	0 325		

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0 325	Continued From page 3 staff members are in the house, so one person can stay with the client during a shower. On 8/16/16 at 1:50 p.m., during an interview, unlicensed personnel (ULP)-E stated right after the incident with C1, staff were educated that all showers must be given when two staff members are present. Showers are done on the day shift and there is a shorter shift that assists in the morning. ULP-E stated if there was not a second person scheduled, then the showers would have to be rescheduled for a different day. During an interview on 8/16/16 at 2:10 p.m., ULP-F stated the clients were always at least a stand by assist for showers and no staff should leave a patient alone while showering. ULP-F stated staff are to stay with the client during a shower to make sure everything is safe. In addition, ULP-F stated after the incident occurred with C1, she received an email reminding staff that all showers must be given only when there are two staff members present in the facility. During an interview with C1 on 8/16/16 at 3:35 p.m., C1 stated during showers she does everything herself and staff gather her things and turn the water on. C1 stated that day she was feeling good. C1 stated she got out of the shower unassisted and when she was drying herself, she saw something on her big toe. C1 stated she fell head first and remembers waking up in the hospital. On 9/19/16 at 2:10 p.m., an interview with RN-D stated C1 was a fall risk and had a history of light headed episodes. RN-D stated C1 had her standing and sitting blood pressures monitored. Also, RN-D stated there were two staff at the licensee and showers were supposed to be done	0 325		

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0 325	Continued From page 4 when two staff were present, but was aware that was not being done all of the time. RN-D stated she did raise that issue to the licensee owners. RN-D added that when she trained unlicensed personnel, she verbally told staff not leave clients alone in the shower. During an interview on 9/16/16 at 3:00 p.m., ULP-G stated that on the day of the incident, C1 was the first client up for the day. ULP-G started C1's shower. ULP-G stated C1 liked to complete washing and doing her hair independently. ULP-G explained that she assisted C1 into the shower and then left C1 unattended to gather supplies in C1's room. ULP-G stated she heard crashing and yelling from the bathroom and ran in to find C1 on the floor, bleeding from the back of her head. ULP-G stated C1 will usually wait for assist prior to getting out of the shower. ULP-G stated when she left C1, C1 was sitting on the shower chair. ULP-G suspected that C1 fell sideways hitting her head on the raised toilet seat arms. ULP-G stated she held a towel under C1's head, called 911, and contacted the family, the RN, and the licensee owner. ULP-G stated she stayed with C1 until paramedics arrived and transported C1 to the hospital. ULP-G stated after the incident occurred she received an email stating all staff need two staff members present to give clients showers. ULP-G then began to see a second person on the schedule. During an interview with Administrator-A on 9/19/16 at 4:40 p.m., Administrator-A stated showering requirements are determined by the RN assessment. If a client is a stand by assist, staff are expected to assist the client in and out of the shower and to stay in the bathroom at all times during the shower.	0 325		

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0 325	Continued From page 5 The licensee policy titled "Policy and Procedure on Showering/Bathing Residents" dated 9/14/16, indicated supplies should be gathered prior to starting the shower. If a client is full assist, staff must not leave the client unattended. Administrator-B stated the showering policy was the only one in effect during 3/5/16. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		
0 840 SS=I	144A.4791, Subd. 4 Acceptance of Clients Subd. 4. Acceptance of clients. No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to provide adequate staffing to meet client standards of having two staff present when showers were provided for four of five clients (C1, C2, C3, C4) reviewed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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). The findings include:	0 840		

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0 840	Continued From page 6 Document review of the licensee's unlicensed personnel schedule dated 2/21/16 through 3/19/16, indicated there was one unlicensed staff scheduled during each shift. Each shift was a twelve hour shift (6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m.). On the weekends, the evening twelve hour shift was divided in half between two staff (6:00 p.m. to 12:00 a.m. and 12:00 a.m. to 6:00 a.m.). C1's medical record was reviewed. C1 was admitted to the licensee on 12/1/13 with diagnoses that included dementia, syncope and collapse, and cerebral ischemia. C1's service plan, dated 7/30/15, indicated C1 required assistance with dressing/grooming twice a day, set-up assist for eating, continence care four to five times a day, cleaning dentures daily, bathing twice a week and tag alarm on while sleeping. C1 experienced a fall on 3/5/16, with serious injuries which included cervical fractures. C1 had been left unattended in the shower when unlicensed personnel (ULP)-G had left to retrieve items from C1's room, across from the bathroom. ULP-G was the only staff member scheduled from 6:00 a.m. to 6:00 p.m. on 3/5/16. C2's medical record was reviewed. C2 was admitted to the licensee on 11/30/13 with diagnoses that included Alzheimer's disease. C2's service plan dated 9/13/15 indicated C2 required assistance with daily dressing/grooming and eating, bathing once a week and laundry/housekeeping as needed. C3's medical record was reviewed. C3 was admitted to the licensee on 12/28/12 with	0 840		

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0 840	Continued From page 7 diagnoses that included dementia. C3's service plan dated 8/23/15 indicated C3 required assistance with dressing/grooming twice a day, set-up assist for eating, continence care four to five times a day, bathing twice a week, three loads of laundry a week and two linen changes a week. C4's medical record was reviewed. C4 was admitted to the licensee on 1/18/16 with diagnoses that included dementia. C4's service plan dated 3/14/16 indicated C4 required assistance with set-up assist for eating, bathing twice a week, three loads of laundry a week and two linen changes a week. C5's medical record was reviewed. C5 was admitted to the licensee on 3/31/16 with diagnoses that included viral traumatic brain injury. C5's service plan dated 6/30/16 indicated C5 required assistance with continence care every two hours, set-up assist for eating, bathing twice a week, three loads of laundry a week and two linen changes a week. During an on-site visit on 8/16/16, upon entering the licensee at 10:00 a.m., one staff was present. An unlicensed personnel from an outside hospice agency was present assisting a client, however no other licensee staff present. At 12:00 p.m., a second staff member arrived to help assist with lunch. During an interview with registered nurse (RN)-C on 8/16/16 at 1:40 p.m., RN-C stated an unlicensed personnel should be with a client at all times during a shower. RN-C stated usually there are two staff working in the morning, one works a four hour shift to help assist other clients while baths are done.	0 840		

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0 840	Continued From page 8 On 8/16/16 at 1:50 p.m., an interview with ULP-E stated right after the incident on 3/5/16 involving C1's fall in the shower, it was communicated to staff by management that all showers need to be given when two staff members are present. ULP-E stated a second staff member has been scheduled 7:00 a.m. to 11:00 a.m. ULP-E explained sometimes a second staff member is not available, and then no showers are provided to clients that day. ULP-E stated they will then try to complete the showers another day. ULP-E stated she has had to give showers when she was the only staff member scheduled. In addition, ULP-E stated it would be difficult to assist all clients in an emergency with one scheduled staff member. During an interview on 8/16/16 at 2:10 p.m., ULP-F stated the same week C1 experienced a fall on 3/5/16, ULP-F received an email from management stating there needs to be two staff present when showers are given and a client is not to be left alone during a shower. ULP-F stated a shorter shift had been scheduled after that email Monday through Friday 6:00 a.m. to 10:00 a.m. ULP-F stated having a second staff member scheduled would be helpful because anything could happen at anytime and an extra pair of hands would be useful if one staff member is working with a difficult client. On 9/13/16 at 3:24 p.m., an interview with RN-D stated showers were supposed to be done when two staff were present, however, this was not always practiced. RN-D stated she did raise that issue with management. In addition, RN-D stated she trained unlicensed staff to not leave clients alone in the shower.	0 840		

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	H24603	A. BUILDING: _____ B. WING _____	C 09/19/2016

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0 840	Continued From page 9 During an interview with ULP-G on 9/16/16 at 3:00 p.m., ULP-G stated after the incident involving C1, management sent an email stating there needs to be two staff present whenever showers are completed and then started scheduling a second staff member for a couple hours in the morning. Prior to the incident, ULP-G stated there was only one staff member working and there were two showers to be given everyday. An interview with Administrator-A on 9/19/16 at 4:40 p.m. Administrator-A stated two staff were scheduled in the house at all times for baths going forward after the incident involving C1. Two staff had been scheduled for most of the day until two weeks ago, now a second staff member is scheduled just when showers are needed. On 9/21/16 at 10:00 a.m., during an interview with C1's family member, the family member stated the licensee management staff had called to explain that a second staff member was no longer going to be scheduled because of staffing difficulties and there would be one staff member scheduled per shift. The licensee policy titled "Resident Supervision Policy" dated 9/14/16, indicated staff are to be a the facility at all times and aware of the residents whereabouts. A resident may be unsupervised while napping or sleeping at night and may be unable to be directly supervised when a caregiver is performing other duties. The resident's care plan must be followed for each resident and every resident must be checked by the caregiver every two hours during sleeping hours. TIME PERIOD FOR CORRECTION: Twenty One	0 840		

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0 840	Continued From page 10 (21) days	0 840		
0 860 SS=D	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to complete a RN reassessment within fourteen days of admission for one of five	0 860		

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0 860	Continued From page 11 clients (C5) 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 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: C5's medical record was reviewed. C5 was admitted to the licensee on 3/31/16 with diagnoses that included viral traumatic brain injury. On 8/16/16, no RN assessments were found in C5's medical record. The admission RN assessment was not present, the fourteen day RN assessment due 4/14/16 was not present, and a ninety day RN assessment due 7/14/16 was not present. Upon request for assessments, a completed admission RN assessment dated 3/31/16, and two RN assessments dated 4/26/16 and 7/20/16, were provided. The fourteen day assessment was out of compliance by twelve days. On 8/25/16 at 5:03 p.m., an email was received by Administrator-B with the attached RN assessments for C5. Administrator-B stated there was no record of a completed fourteen day assessment for C5, so the RN completed the assessment at thirty days after admission. The licensee policy titled "Comprehensive Assessment, Monitoring and Reassessment" dated 9/14/16, resident monitoring and RN reassessment must be completed within fourteen days after the initiation of services.	0 860		

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0 860	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 860		
0 865 SS=F	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the 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	0 865		

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0 865	Continued From page 13 informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to document all services provided to five of five clients (C1, C2, C3, C4, C5) 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). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee with diagnoses that included dementia, syncope and collapse, and cerebral ischemia. C1's service plan dated 7/30/15 indicated C1 required assistance with dressing/grooming twice a day, set-up assist for eating, continence care four to five times a day, cleaning dentures daily, bathing twice a week and tag alarm on while sleeping. C2's medical record was reviewed. C2 was admitted to the licensee with diagnoses that included Alzheimer's disease. C2's service plan dated 9/13/15 indicated C2 required assistance with daily dressing/grooming and eating, bathing once a week and laundry/housekeeping as needed. C3's medical record was reviewed. C3 was	0 865		

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0 865	Continued From page 14 admitted to the licensee with diagnoses that included dementia. C3's service plan dated 8/23/15 indicated C3 required assistance with dressing/grooming twice a day, set-up assist for eating, continence care four to five times a day, bathing twice a week, three loads of laundry a week and two linen changes a week. C4's medical record was reviewed. C4 was admitted to the licensee with diagnoses that included dementia. C4's service plan dated 3/14/16 indicated C4 required assistance with set-up assist for eating, bathing twice a week, three loads of laundry a week and two linen changes a week. C5's medical record was reviewed. C5 was admitted to the licensee with diagnoses that included viral traumatic brain injury. C5's service plan dated 6/30/16 indicated C5 required assistance with continence care every two hours, set-up assist for eating, bathing twice a week, three loads of laundry a week and two linen changes a week. The service task logs for C1, C2, C3, C4, C5 dated June 2016 and July 2016 only indicated the services for showers, room cleaning and bedding washed as tasks for the unlicensed personnel to sign for when the service was provided. There was no documentation any other service was provided including, dressing/grooming, assistance with eating, continence care, laundry, oral care, or safety interventions. In addition the three services that were included on the service task log did not indicate the frequency or time provided for the service. During an interview on 8/16/16 at 1:00 p.m., unlicensed personnel (ULP)-E stated the service	0 865		

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0 865	Continued From page 15 task logs were the only record of documented services provided. ULP-E stated there was no other form used by staff. On 8/16/16 at 1:05 p.m., an interview with Administrator-B stated she did not know that all the services provided were supposed to be documented. On 10/12/16 at 10:41 a.m., an email from Administrator-B was received and stated there was no policy related to service plans for the licensee. No licensee policy related to service plans was provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 865		
01080 SS=D	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	01080		

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01080	Continued From page 16 records; (5) client's advance directives, if any; (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. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to maintain registered nurse (RN) assessments in the clients record for one of five clients (C5) reviewed.	01080		

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01080	Continued From page 17 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 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: C5's medical record was reviewed. C5 was admitted to the licensee on 3/31/16 with diagnoses that included viral traumatic brain injury. On 8/16/16, no RN assessments were found in C5's chart: no admission RN assessment was present, the fourteen day RN assessment due 4/14/16 was not present, and the ninety day RN assessment due 7/14/16 was not present. During an interview on 8/16/16 at 1:05 p.m., Administrator-B stated C5 was a newer client, and the RN assessments had not been placed in the chart yet. A policy related to the contents of client records was requested. No policy was provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01080		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated,	02015		

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02015	Continued From page 18 or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead	02015		

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02015	Continued From page 19 agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to report when a client who required assistance was left alone in the shower, fell, and experienced a cervical fracture for one of five clients (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 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: C1's medical record was reviewed. C1 was admitted with diagnoses that included dementia, syncope and collapse, and cerebral ischemia. C1's service plan dated 7/30/15 indicated the client required assistance with bathing twice a week.	02015		

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02015	Continued From page 20 An incident report dated 3/5/16 indicated C1 fell while in the shower at 6:50 a.m. Unlicensed personnel (ULP)-G had completed the incident report and indicated C1 was in the shower and ULP-G was outside of the bathroom in the medication closet. ULP-G heard C1 fall and yell. ULP-G immediately went into the bathroom and found C1 on the floor, bleeding from the back of her head. ULP-G held a towel to the back of C1's head, called 911 and stayed with C1 until paramedics arrived. C1 was admitted to the hospital. C1's hospital report dated 3/5/16 through 3/9/16 indicated C1 experienced cervical fractures. C1 required a halo cast with pins procedure for stability of the fractures. C1 was discharged on hospice back to the licensee. During an on-site investigation on 8/16/16, the bathroom where C1 had fallen was observed. The bathroom is located across the hallway from C1's room. The bathroom is narrow, approximately a nine foot by five foot space. The bathtub is tub/shower combo with a raised edge. Inside the tub is a shower chair. Across from the tub is the toilet with a raised toilet seat that has metal handle bars. Directly to the right of the toilet is a wood vanity. That day C1 was observed wearing a hard cervical collar. C1 required assistance of one staff member and walker for ambulation. C1 spent the majority of her time resting in a recliner in the living room. C1 did ambulate with staff to the dining room for meals. No call light system or a way for clients to alert staff was observed throughout the licensee. During an interview with C1 on 8/16/16 at 3:35 p.m., C1 stated during showers she does	02015		

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02015	Continued From page 21 everything herself and staff gather her things and turn the water on. C1 stated she got out of the shower unassisted and when she was drying herself, she saw something on her big toe. C1 stated she fell head first and remembers waking up in the hospital. On 9/19/16 at 2:10 p.m., an interview with RN-D stated C1 was a fall risk and had a history of light headed episodes. RN-D stated she has been asked by the licensee owners to submit a vulnerable adult report before, however, she did not think maltreatment occurred in this incident. During an interview with Administrator-A on 9/19/16 at 4:40 p.m., Administrator-A stated showering requirements are determined by the RN assessment. If a client is a stand by assist, staff are expected to assist the client in and out of the shower and to stay in the bathroom at all times during the shower. Administrator-A stated she did not submit a vulnerable adult report because she assumed if a client is sent to the hospital, the hospital always submits a report. The licensee policy titled "Policy and Procedure on Showering/Bathing Residents" dated 9/14/16, indicated supplies should be gathered prior to starting the shower. If a client is full assist, staff must not leave the client unattended. Adminstrator-B stated the showering policy was the only one in effect during 3/5/16. The licensee policy titled "Maltreatment of Vulnerable Adults Reporting Policy" dated 9/14/16, indicated the licensee follows the definitions of maltreatment and if maltreatment is suspected, a report to the common entry report will be made as soon as possible, but no longer than twenty-four hours. Administrator-A will	02015		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GONDOLA GROUP INC	8615 BIRCH BLVD INVER GROVE HEIGHTS, MN 55076

(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
02015	Continued From page 22 complete the internal investigation and Administrator-B will complete the internal review of the individual involved. TIME PERIOD FOR CORRECTION: Twenty One (21) days	02015		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 15, 2017

Ms. Darlene Davis, Administrator
Gondola Group, Inc.
8615 Birch Blvd.
Inver Grove Heights, MN 55076

RE: Complaint Number HL24603010

Dear Ms. Davis :

On June 14, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on September 19, 2016 with orders received by you on November 3, 2016. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/ja
Enclosure

cc: Home Health Care Assisted Living File
Dakota County Adult Protection
Office of Ombudsman
MN Department of Human Services