



Minnesota Department of Health

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Triple Angels Healthcare Company			Report Number: HL25202004	Date of Visit: February 11 and 12, 2016
Facility Address: 7957 80th Street S			Time of Visit: 10:30 a.m. – 5:30 p.m. and 9:30 a.m. – 2:30 p.m.	Date Concluded: December 30, 2016
Facility City: Cottage Grove			Investigator's Name and Title: Karen Johnson, RN	
State: Minnesota	ZIP: 55016	County: Washington		

Home Care Provider/Assisted Living

Allegation(s):

It is alleged that a client was physically abused when the alleged perpetrator (AP) restrained the client's hands behind the wheelchair, pinning the client's arms. In addition, the client was emotionally abused when the AP left the client in a bathroom without assistance, although the client was yelling for help.

- 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 the evidence, abuse occurred when the alleged perpetrator (AP) hit the client on the right arm, causing bruising, and unreasonably confined the client by positioning the client's arms in a way that limited the client's movement.

At the time of the incident, the client had received services from the home care provider for six weeks. The client had a history of yelling and hitting staff. The client was wheelchair bound but able to maneuver the wheelchair independently. The client required supervision of one staff while in the community.

On the day of the incident, the client and the AP were at a medical clinic for an appointment. When the appointment was completed, their return transportation was delayed.

Due to the unforeseen delay, the client became agitated, yelled more frequently, and made repeated attempts to roll the wheelchair out of the building. Witnesses described the AP as disengaged and annoyed by the client's behavior. The AP sat in the waiting area and, as necessary, got up and pulled the client's wheelchair back into the building.

The client's yelling of profanities caught the attention of another individual at the clinic. This individual observed the AP hit the client on the right mid-arm area several times, heard the client say "Don't you hit me!" and heard the AP say "I'm going to lock you in the bathroom." The AP then pushed the client, in the

wheelchair, down a hall. The witness heard a door close and the sound of someone yelling "Help! Help!" The witness walked down the hall to the direction of the voices, and saw the client sitting in a wheelchair outside of the bathroom with his/her arms in a position described by the witness as "jammed in the wheelchair so [s/he] could not move them." The client's right upper arm was put behind him/her and positioned over the back of the right upper area of the wheelchair and tucked under the right wheelchair handle. The left upper arm was also positioned over the back of the left upper area of the wheelchair and wedged and tucked under the left wheelchair handle. With the clients arms incapacitated, s/he could no longer maneuver the wheelchair. The client then asked the witness, "Could you take my arms out please?" The witness released the client's arms from the wheelchair handles.

Another witness, a clinic employee, observed the AP grab one of the client's arms, position it backwards and wedge it under one of the wheelchair handles. The AP then rolled the client down a hallway in the wheelchair until they were out of sight. The clinic employee then heard the client yelling for help.

Three days after the incident, bruises on the client's right arm and hand, as well as bruises on both upper arms, were still present.

The AP was interviewed, and denied hitting or restraining the client. The AP acknowledged bringing the client to the bathroom to calm him/her down. The AP said s/he left the bathroom for less than a minute to check to see if their transportation had arrived.

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 facility had a vulnerable adult policy and procedure in place, and the AP had been educated on these policies.

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 Statutes 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 2 - Abuse

"Abuse" means:

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

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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

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:

- Medical Records
- Care Guide
- Medication Administration Records
- Weight Records
- Nurses Notes
- Assessments
- Physician Orders
- Treatment Sheets
- Physician Progress Notes
- Care Plan Records
- Social Service Notes
- Facility Incident Reports
- Activities Reports
- Laboratory and X-ray Reports
- Therapy and/or Ancillary Services Records
- ADL (Activities of Daily Living) Flow Sheets
- Service Plan

Other pertinent medical records:

- Hospital Records
- Police Report

Additional facility records:

- Staff Time Sheets, Schedules, etc.
- Facility Internal Investigation Reports

- Personnel Records/Background Check, etc.
- Facility In-service Records
- Facility Policies and Procedures

Number of additional resident(s) reviewed: 2

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

Specify: _____

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: No family involved with vulnerable adult

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: 8

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

Tennessee Warnings

Tennessee Warning given as required: Yes No

Total number of staff interviews: 4

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

Facility Name: Triple Angels Healthcare
Company

Report Number: HL25202004

Were contacts made with any of the following:

Emergency Personnel Police Officers Medical Examiner Other: Specify Legal Guardian

Observations were conducted related to:

- Personal Care
- Nursing Services
- Infection Control
- Cleanliness
- Dignity/Privacy Issues
- Safety Issues
- Meals
- 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

Cottage Grove Police Department

Washington County Attorney

Cottage Grove City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H25202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2016
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NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE CO	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 80TH STREET SOUTH COTTAGE GROVE, MN 55016
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments INITIAL COMMENTS: On 02/11/2016, a complaint investigation was initiated to investigate complaint #HL25202004. At the time of the survey, there were ten clients receiving services under the comprehensive license. The following correction orders are issued.	0 000	*****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.	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (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 document review and interview, the comprehensive home care provider failed to ensure that one of ten clients (C1) was free from maltreatment when C1 was hit on the arm and restrained in a wheelchair, which resulted in extensive bruising to both arms and right hand, and was isolated in a public bathroom with the door closed.	0 325		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 325	<p>Continued From page 1</p> <p>This resulted in a level 4 violation (a violation that results in serious injury, impairment, or death), and is 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:</p> <p>C1's medical record was reviewed. C1 was admitted to the comprehensive home care provider on 01/05/2016. C1's nursing assessment was dated 01/05/2016 and completed by registered nurse (RN)-J. C1 was assessed to be hard of hearing, forgetful and confused, but able to talk with staff to express herself. C1 had a history of aggressive and combative behavior during personal cares. The nursing assessment indicated C1 required supervision of one staff for eating and medication management and she required the assistance of one to two staff for personal cares. C1 was able to maneuver herself in her wheelchair.</p> <p>The plan of care, dated 01/05/2016, was completed by RN-J and indicated the client needed one to three person assistance with transfers due to being unable to bear own weight.</p> <p>The service plan, dated 01/05/2016 and completed by RN-J, indicate all activities of daily living were to be completed by staff. No other specific directions were noted.</p> <p>The vulnerability assessment, completed on 01/05/2016 by RN-J, indicated C1 required continual supervision due to her not being orientated to person, time or place. C1 was susceptible to abuse by others in the home environment and was at risk for abusing other vulnerable adults.</p>	0 325		
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0 325	<p>Continued From page 2</p> <p>On 01/16/2016, C1's plan of care was updated by RN-A. C1 was requiring assistance of three to four secondary to physical aggression such as kicking, screaming, spitting and slapping at staff when cares were attempted. On 01/20/2016, due to C1's physical aggression and resistance to cares, a nursing re-evaluation was completed by RN-A which reflected C1's clinical changes.</p> <p>An interview with community member (CM)-F was conducted on 02/22/2016 at 3:10 p.m. On 02/08/2016 at 6:45 p.m., CM-F arrived at a local medical clinic and observed C1 in her wheelchair attempting to go outside unescorted. Personal Care Attendant (PCA)-C was pulling C1 back into the building by her wheelchair. C1 was yelling profanities toward PCA-C. As PCA-C was pulling C1 back into the building, C1 was heard to say; "Don't you hit me!" CM-F then saw PCA-C hit C1 on the right middle arm area several times. C1 continued to yell profanities. CM-F then stated; "I heard him say he was going to lock her in the bathroom." CM-F then saw PCA-C pushing C1 in her wheelchair down a hallway. She could not see them but heard a door close. She then heard an echoing sound of someone, who was thought to be C1 yelling; "Help! Help!" CM-F was unsure how long this went on but described it as, "not very long." CM-F then walked down the hall and saw C1 sitting outside the woman's bathroom in a wheelchair. CM-F stated C1's arms were "Jammed in the wheelchair so she could not move them."</p> <p>The left arm was placed behind and over the back of the wheel chair and tucked under the left handle so it was wedged tightly in the wheelchair and the right arm was placed behind and over the back of the wheel chair and wedged tightly under</p>	0 325		
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0 325	<p>Continued From page 3</p> <p>the right handle. C1 was unable to get her arms out. C1 then said to CM-F; "Could you take my arms out please?" C1 did not seem to be in pain but had noticeable bruising on both arms. CM-F released C1's arms from the back of the wheelchair handles with caution. CM-F stated "I was afraid I would hurt her, they were jammed in."</p> <p>An interview with a community member employed at the medical clinic (CM)-G was conducted on 02/23/2016 at 12:10 p.m.. CM-G could not recall the exact date but did remember the incident. She arrived at the clinic for her shift at 4:45 p.m. and immediately noticed C1 and PCA-C. C1 was in her wheelchair and was attempting to roll herself outside. PCA-C brought her back in several times by rolling her backwards. At one point PCA-C grabbed one of C1's arms and placed it behind and over the back of the wheelchair and wedged it under the wheelchair handle. PCA-C then rolled C1 down a hallway until they were out of CM-G's sight. R-G could hear C1 yelling; "Please help me!" and "Let me go!" and "Help me, untie me!" The clinic staff then notified the Cottage Grove Police Department. When the police arrived, PCA-C and C1 had already left the clinic.</p> <p>An interview with PCA-C was conducted on 02/11/2016 at 4:00 p.m. On the day of the incident, PCA-C stated he escorted C1 to an appointment at a medical clinic and when it took three hours for the transportation to arrive to go home, C1 yelled and screamed. PCA-C was unsure why C1 was yelling and screaming, assuming was from frustration and fatigue.</p> <p>C1 continually attempted to roll herself out the front door of the medical clinic. PCA-C pulled C1</p>	0 325		
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0 325	<p>Continued From page 4</p> <p>away from the doorway multiple times. PCA-C denied striking C1 or putting C1's arms in a position that prevented C1 from maneuvering her wheelchair. PCA-C stated C1 may have gotten into the position when she turned her torso around and put one arm over the back of the wheelchair. PCA-C confirmed putting C1 into the clinic bathroom because C1 said "Help me, help me" which meant C1 wanted to go into the bathroom. PCA-C stated he would do whatever C1 wanted in order to calm her down. PCA-C confirmed C1 was in the bathroom alone for less than a minute when PCA-C looked out to see if the transportation vehicle had arrived. PCA-C denied hitting, threatening or abusing C1 in any way.</p> <p>An interview with C1 was conducted on 02/11/2016 at 1:05 p.m.. C1 was confused and mildly agitated. C1 did not recall the incident at the medical clinic and did not know how she got the bruises on her arms and hand. She denied feeling frightened or unsafe.</p> <p>On 02/11/2011 at 1:05 p.m. and at 3:00 p.m., observations were conducted. C1 had bruising to the right hand and both arms, including: First, a bruise at the top of the right wrist measured three fourths of an inch in diameter and was purple and red in color. Second, a bruise on the top of the right hand, above the small finger, measured one half of an inch in diameter and was purple and red in color. Third, a bruise at the top of the right hand on the center knuckle measured three fourths of an inch in diameter and was purple and red in color. Fourth, the left lower mid-arm had one bruised area which measured six and one half inches by four inches and was purple and red in color. Fifth, the left upper arm at the middle-inner area</p>	0 325		
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0 325	<p>Continued From page 5</p> <p>measured six inches by four and one half inches and was dark purple and pink in color. Sixth, the right upper arm at the middle-inner below the arm pit had two bruised areas. The first measured six inches by three inches and was faded dark yellow and faded brown in color. The second bruise was higher up on the inner arm and measured two and one half inches in diameter and was faded yellow in color.</p> <p>Triple Angel's policy titled: Vulnerable Adult/Child Protection, Effective January 13, 2014 was in place. Vulnerable Adult was defined as "Anyone 18 years of age or older, who regardless of where the person is living, is unable to unlikely to report abuse or neglect without assistance because of impairment of mental or physical function, or emotional status." Abuse was defined as; "Non-therapeutic conduct which produces or could reasonable be expected to produce pain injury and is not accidental or any repeated conduct which produces or could reasonable be expected to produce mental or emotional distress."</p> <p>Triple Angels Position Description - Personal Care Assistant was signed by PCA-C on 03/20/2014. The Personal Care Assistant's Job Responsibilities were included but not limited to: "Promotes a safe and comfortable environment for the resident and family, recognizes and manages own stresses, which may affect work performance and adheres to all policies of Triple Angel's."</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 325			



Protecting, Maintaining and Improving the Health of All Minnesotans

August 22, 2017

Mr. Adenike Ogunrinde, Administrator
Triple Angels Healthcare Co
7957 80th Street South
Cottage Grove, MN 55016

RE: Complaint Number HL25202004

Dear Mr. Ogunrinde:

On August 21, 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 December 22, 2016 with orders received by you on December 28, 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,

A handwritten signature in cursive script that reads "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
Washington County Adult Protection
Office of Ombudsman
MN Department of Human Services