MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Oxford Property Management LLC	HL28279002	December 22, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
206 So. Broadway Suite 400	9:00 a.m. to 3:45 p.m.	August 10, 2017
Facility City:	**Investigator's Name and Title:**	
Rochester	Kathleen Smith DNP, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55904	Olmsted

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when s/he had a change in condition, including symptoms of confusion, weakness, and dizziness and the client fell. The client was hospitalized and hospital staff found the client had three pain patches on, instead of one. The client had an overdose of fentanyl pain patches.

☒ 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 occurred when the facility failed to ensure staff appropriately applied, removed, and documented fentanyl patch administration. Consequently, the client received an overdose of fentanyl, slumped to the ground, and hit his/her head. The client went to the hospital by ambulance and was admitted for four days.

The client received services from the provider, which was licensed as a comprehensive home care provider. The client's diagnoses included backache and atrial fibrillation. The client received medication management services from the home care provider. After having previously received lower dose fentanyl patches (opioid pain medication), the client was prescribed a 50 microgram (mcg) fentanyl patch, to be applied every three days. Documentation showed the client received the 50 mcg patch on two dates.

After the second 50 mcg patch application, the client became lightheaded, slumped to the ground, and hit his/her head. The client went to the hospital by ambulance and was admitted for four days. One fentanyl patch was removed by emergency medical services and two more patches were removed in the emergency department at the hospital. The client needed oxygen and IV fluids. During the hospital admission, X-rays

and CT scans were conducted to check for injuries.

The medication administration record (MAR) for the lower dose patch directed staff to use one patch every three days with no further instructions. The MAR for the 50 mcg patch directed staff to use one patch every three days and provided instructions for patch removal and disposal. The facility policy on medication patches instructed staff to follow the MAR directions related to removal of patches. Additionally, the policy instructed staff to document the time of patch removal and the location of the new patch on the MAR.

During an interview, a direct care staff member stated the patch was to be removed on one shift and reapplied on another shift. The staff member was unable to explain how this would be documented in the medication record.

During an interview, a nurse stated that all staff were educated regarding the medication, including correct application, removal, disposal, side effects, and documentation. However, there were no documents or interviews to support this training activity. The nurse stated there was no documentation of the application site or the date for removal on the medication document for the client.

After the incident, the prescriber ordered the patches with directions to date patches with a removal date when applied. The facility created a chart to document the location and date of patches on the client's body and posted a paper sign to remind staff to date each patch with a removal date using a permanent marker.

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 failed to ensure staff were following medication procedures for fentanyl patches when the staff did not remove the previous patch when applying a fresh patch.

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:

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] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Treatment Sheets
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: None

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, 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: Family preferred no visit with the resident.

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Three

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:

☒ Personal Care

☒ Nursing Services

☒ Call Light

☒ 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

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Fillmore County Sheriff's Office
Fillmore County Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28279	A. BUILDING: _____ B. WING _____	R-C 10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD PROPERTY MANAGEMENT LLC	421 1ST AVE SW ROCHESTER, MN 55902

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{0 000}	Initial Comments A licensing order follow-up was completed to follow up on correction orders issued related to complaint HL28279002. Oxford Property Management was found in compliance with state regulations.	{0 000}		

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 15, 2017

Ms. Kim Worrall, Administrator
Oxford Property Management Llc
421 1st Ave Sw
Rochester, MN 55902

RE: Complaint Number HL28279002

Dear Ms. Worrall:

On October 6, 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 August 10, 2017. At this time these correction orders were found corrected.

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
Supervisor 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

MLH

Enclosure

cc: Home Health Care Assisted Living File
Fillmore County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

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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, these correction orders are 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 December 22, 2016, a complaint investigation was initiated to investigate complaint #HL28279002. At the time of the survey, there were 27 clients receiving services under the comprehensive license, five of these clients were in memory care. 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 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. 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 Minn. Stat. 144A.474 subd. 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 interview and document review, the facility failed to ensure clients were free from maltreatment (neglect) for one of one clients (C1) reviewed. Client #1 (C1) had physician orders for a fentanyl (pain medication) patch, 50 micrograms (mcg) every three days. The patch was supposed to be removed when a new one was placed. C1 became lightheaded, slumped to the ground, hit his/her head, and required hospitalization. At that time, it was discovered C1 had three fentanyl patches in place. 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 very limited number of residents are affected and/or one of a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations). The findings include: C1 began receiving services in early 2015, for diagnoses that included dizziness, backache, and atrial fibrillation. The Client Individualized Medication Management Plan, dated January 12, 2015, indicated C1 received medication set up and medication administration services. A review of the medication administration record (MAR) for C1, dated October 2015, revealed C1 received a	0 325		

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0 325	Continued From page 2 fentanyl patch of 12 mcgs every three days. A review of the MAR for November 2015 documented C1 received the fentanyl patch 25 mcgs on November 4, 7, 10, 23, 26 and 29. An Order Requisition Form dated November 11, 2015 revealed the fentanyl patch was changed to 50 mcgs. every three days. C1 received the fentanyl patch 50 mcgs. on November 12 and 15, 2015, and was hospitalized from November 16-20, 2015. A medical record dated November 16, 2015 at 3:39 p.m. noted C1 had a fentanyl patch removed by Emergency Medical Service (EMS), and two more patches were removed in the emergency department (ED). A review of the MAR's for October and November 2015, revealed no dates for patch removal or documentation of the patch application site. During an interview on December 22, 2016 at 12:31 p.m., Unlicensed Personnel (ULP)-K stated patches were to be removed on the night shift, replaced on the day shift, and then on the body sheet, the placement and date to be removed should be documented. ULP-K did not recall how to document patch administration on the MAR. ULP-K signed as having received the Medication Errors policy on November 9, 2013, however when the policy was requested from the facility, it was not received by the surveyor. An interview with Registered Nurse (RN)-P, on December 22, 2016 at 10:18 a.m, indicated directives were provided to the staff regarding the specific medication and client, staff were instructed to remove one patch prior to applying another patch, staff were instructed how to dispose of the patch, how to document, and common side effects of the medication. Also, during the interview RN-P stated there was no documentation on the MARs for the patch	0 325		

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0 325	Continued From page 3 removal for C1 for the months of October and November 2015. A review of the Administration of Transdermal Patch policy, dated January 2014, revealed the time of patch removal should be documented on the MAR, additionally the policy states the site of application of the new patch should be documented on the MAR. Time Period for Correction: Twenty-one (21) days.	0 325		
0 805 SS=G	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report suspected maltreatment of a client for one of one clients (C1) reviewed. Client #1 (C1), had physician orders for a fentanyl (pain medication) patch, 50 micrograms (mcg) every three days. The patch was supposed to be removed when a new one is placed. C1 became lightheaded, slumped to the ground, hit his/her head, and required hospitalization. At that time, it was discovered C1 had three fentanyl patches in place. The licensee did not report the incident. 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 very	0 805		

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0 805	Continued From page 4 limited number of residents are affected and/or one of a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations. The findings include: C1 began receiving services in early 2015, for diagnoses that included dizziness, backache, and atrial fibrillation. The Client Individualized Medication Management Plan, dated January 12, 2015, indicated C1 received medication set up and medication administration services. A review of the medication administration record (MAR) for C1, dated October 2015, revealed C1 received a fentanyl patch of 12 mcgs every three days. A review of the MAR for November 2015 documented C1 received the fentanyl patch 25 mcgs on November 4, 7, 10, 23, 26 and 29. An Order Requisition Form dated November 11, 2015 revealed the fentanyl patch was changed to 50 mcgs. every three days. C1 received the fentanyl patch 50 mcgs. on November 12 and 15, 2015, and was hospitalized from November 16-20, 2015. A medical record dated November 16, 2015 at 3:39 p.m. noted C1 had a fentanyl patch removed by Emergency Medical Service (EMS), and two more patches were removed in the emergency department (ED). A review of the MAR's for October and November 2015, revealed no dates for patch removal or documentation of the patch application site. During an interview on December 22, 2016, Registered Nurse (RN)-K stated the incident was not reported to the Common Entry Point (CEP). RN-K stated an incident report was completed for the incident. During an interview on December 22, 2016, at 11:49 a.m., RN-A stated there was no incident	0 805		

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0 805	Continued From page 5 report for the incident with C1. A copy of the incident report or internal investigative report was requested from the facility, but was not received. There was no CEP report submitted by this facility which matched this incident. A facility policy, dated November 3, 2014, stated a medication error requiring care by a physician must be reported immediately to the CEP. This same document revealed an investigation would be led by the RN, and the Medication Incident Report Form would be completed. Time Period for Correction: Twenty-one (21) days.	0 805		
0 935 SS=G	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed	0 935		

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0 935	Continued From page 6 and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document administration of medications as prescribed for one of one clients (Client #1 (C1)). C1 had physician orders for a fentanyl (pain medication) patch, 50 micrograms (mcg) every three days. The patch was supposed to be removed when a new one is placed. C1 became lightheaded, slumped to the ground, hit his/her head, and required hospitalization, at that time it was discovered C1 had three fentanyl patches in place. 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 very limited number of residents are affected and/or one of a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations). The findings include: C1 began receiving services in early 2015, for diagnoses that included dizziness, backache, and atrial fibrillation. The Client Individualized Medication Management Plan, dated January 12, 2015, indicated C1 received medication set up and medication administration services. A review of the medication administration record (MAR) for C1, dated October 2015, revealed C1 received a	0 935		

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0 935	Continued From page 7 fentanyl patch of 12 mcgs every three days. A review of the MAR for November 2015 documented C1 received the fentanyl patch 25 mcgs on November 4, 7, 10, 23, 26 and 29. An Order Requisition Form dated November 11, 2015 revealed the fentanyl patch was changed to 50 mcgs. every three days. C1 received the fentanyl patch 50 mcgs. on November 12 and 15, 2015, and was hospitalized from November 16-20, 2015. A medical record dated November 16, 2015 at 3:39 p.m. noted C1 had a fentanyl patch removed by Emergency Medical Service (EMS), and two more patches were removed in the emergency department (ED). A review of the MAR's for October and November 2015, revealed no dates for patch removal or documentation of the patch application site. During an interview on December 22, 2016 at 12:31 p.m., Unlicensed Personnel (ULP)-K stated patches were to be removed on the night shift, replaced on the day shift, and then on the body sheet, the placement and date to be removed should be documented. ULP-K did not recall how to document patch administration on the MAR. ULP-K signed as having received the Medication Errors policy on November 9, 2013, however when the policy was requested from the facility, it was not received by the surveyor. An interview with Registered Nurse (RN)-P, on December 22, 2016 at 10:18 a.m, indicated directives were provided to the staff regarding the specific medication and client, staff were instructed to remove one patch prior to applying another patch, staff were instructed how to dispose of the patch, how to document, and common side effects of the medication. Also, during the interview RN-P stated there was no documentation on the MARs for the patch	0 935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28279	A. BUILDING: _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD PROPERTY MANAGEMENT LLC	421 1ST AVE SW ROCHESTER, MN 55902

(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
0 935	Continued From page 8 removal for C1 for the months of October and November 2015. A review of the Administration of Transdermal Patch policy, dated January 2014, revealed the time of patch removal should be documented on the MAR, additionally the policy states the site of application of the new patch should be documented on the MAR. Time Period For Correction: Twenty-one (21) days	0 935		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 7795

September 13, 2017

Ms. Kim Worrall, Administrator
Oxford Property Management LLC
421 1st Ave SW
Rochester, MN 55902

RE: Complaint Number HL28279002

Dear Ms. Worrall :

A complaint investigation (#HL28279002) of the Home Care Provider named above was completed on August 10, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

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

Enclosure

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