Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL28789063M
Compliance #: HL28789064C

Date Concluded: April 16, 2021

Name, Address, and County of Licensee Investigated:
Ebenezer – Aurora on France
Edina Senior Living LLC
6500 France Ave S
Edina, MN 55435
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
John Sheridan-Giese, RN, Special Investigator
Michele Larson, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The alleged perpetrator (AP) physically and verbally abused the client when she tried to make the client take her medications against the client's will.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP verbally and physically abused the client, after the client asked the AP to administer her medications. The client sustained a bruise to her right wrist after the AP grabbed and pulled on her wrist. The AP's course of treatment with the client could be considered by a reasonable person to be harassing, humiliating, and threatening.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The client's medical record was reviewed. The investigator reviewed policies and procedures, staff schedules, incident reports and grievances. The client's family member was interviewed.

The client lived in the assisted living wing of the facility. Her medical diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder and atherosclerotic heart disease. The client required oxygen and used a walker and scooter for mobility. The client was oriented to person, place, time, and situation. The client's services included medication administration and management services, safety checks, and access to a call response pendant.

Review of facility documentation showed the client had a scheduled medication administration at 2:00 p.m. Earlier this day, the AP (an unlicensed staff member) told the client she would not administer her medications as the client could take them herself. The client pressed her call response pendant at 2:03 p.m. The AP responded to the client's room, and the AP attempted to pull the client out of bed so she could self-administer her medications. The AP grabbed the client's right wrist. The client told the AP she felt weak and was unable to get out of bed. The AP eventually administered the client's medications. The client's family later notified the facility's management staff the same day of the incident. The client sustained a bruise to her right wrist and reported she was verbally berated by the AP during the incident.

The facility's internal investigation consisted of interviews of the client, licensed and unlicensed staff. The investigation indicated the AP told the client she would not administer her medications at 2:00 p.m., telling the client that she could do it herself. At 2:03 p.m., the client pressed her call response pendant asking for assistance with her medication administration. The investigation indicated the AP answered the client's call at 2:11 p.m., abruptly telling the client she was turning off the client's call pendant and that the client needed to get up and get her own medication. The client reported the AP grabbed and pulled on her right wrist, trying to get the client out of bed so the client could walk over to the medication dispenser located across the room. The client said she felt weak and was unable to get out of bed. The internal investigation indicated the AP eventually administered the client's medications. After the incident, the director of nursing (DON) observed a pink colored bruise on the client's right wrist. The client reported to the DON she felt unsafe around the AP and no longer wanted the AP to provide her cares. The investigation indicated the AP was immediately suspended pending further investigation.

During an interview, the facility Executive Director (ED) indicated it was believed the client was accurate in her reporting, and the client's interaction with the AP caused the client emotional distress.

During an interview, the DON indicated the client was a credible reporter and was adamant about the events that had transpired.

During an interview, the client's family member indicated the client called right after the incident and was extremely shaken and scared. The family member indicated the client was very alert and aware. The family member indicated the client was very afraid to be alone the night of the incident, fearing the AP would come back and harm her. The family member stated they stayed with the client the evening of the incident so the client would feel safe. The family member photographed the client's bruises to her right wrist and emailed the photographs to the ED and

DON the following day. The family member indicated the ED and DON took the incident very seriously. The family member indicated there were no other incidents, and they were satisfied with the outcome of the facility's internal investigation.

During an interview, the AP denied the allegations and indicated she worked a double shift on the day in question and may have been late to the client's room with her medication. The AP indicated she gave the client her medication and then had a conversation with her while sitting on a chair in the client's room.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;

Vulnerable Adult interviewed: No. The client is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation and reported the incident to MDH. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long-Term Care
The Edina Police Department
Hennepin County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28789	A. BUILDING: _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER HOME CARE	2722 PARK AVE SOUTH MINNEAPOLIS, MN 55407

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On March 8, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL28789064C/#HL28789063M. At the time of the survey, there were 108 clients receiving services under the comprehensive license. The following correction orders are issued for #HL28789064C/#HL28789063M, tag indentification 0315, 0325, 0805, 0810, 1252 and 2015.	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)	
0 315 SS=F	144A.44, Subd. 1(a)(12) Served by People Who Are Competent Subdivision 1.Statement of rights. (a) A client who	0 315		

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0 315	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (12) be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure clients were served by staff who were properly trained and competent for one of six clients (C1) reviewed. After the licensee concluded unlicensed personnel (ULP)-E abused C1 during cares, the licensee failed to provide re-education to licensee staff on abuse prevention. 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's medical diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, and atherosclerotic heart disease. C1's signed service plan dated March 26, 2020,	0 315		

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0 315	Continued From page 2 indicated C1 required assistance with bathing, homemaking, medication administration and safety checks two times per day. C1 used a walker and an electric scooter for mobility. C1's care plan dated July 18, 2019, and signed on March 17, 2020, indicated C1 was assessed as being oriented to person, place, and time. C1 was independent in grooming, toileting, transfers, ambulation, and escorts, but required assistance in bathing. Fall interventions included use of a call pendant. C1's internal investigation report dated September 21, 2020, indicated on September 20, 2020, during morning medication administration, ULP-E told C1 she would not administer C1's next medication dose at 2:00 p.m. because C1 she could do it on her own. At 2:03 p.m., C1 pressed her call pendant to ask for assistance with medication administration. The report indicated ULP-E answered C1's call at 2:11 p.m., abruptly telling C1 she was turning off C1's call pendant, and C1 needed to get up and get her own medications. C1 reported ULP-E then grabbed and pulled on C1's right wrist trying to get C1 out of bed so C1 could walk over to the medication dispenser located across the room. C1 said she felt weak and was unable to get out of bed. The report indicated ULP-E eventually administered C1's medications. After the incident, director of nursing (DON)-B observed a pink colored bruise approximately 3/4" wide by 1.5" long on C1's right wrist. C1 said she felt unsafe around ULP-E and no longer wanted ULP-E to provide her cares. ULP-E was suspended following further investigation. The report indicated all ULPs would receive education on performance guidelines.	0 315		

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0 315	Continued From page 3 Review of email correspondence dated October 13, 2020, at 8:42 a.m., executive director (ED)-A wrote to family member (FAM)-G that ULP-E was terminated following C1's incident, and that licensee staff would be retrained on abuse prevention. During an interview on March 8, 2021, at 2:00 p.m., ED-A said staff were not retrained on abuse prevention. ED-A said the licensee's termination of ULP-E's employment was sufficient and required no further actions by the licensee. During an interview on March 8, 2021, at 1:00 p.m., director of nursing (DON)-B stated no retraining of staff regarding abuse prevention occurred after the incident involving C1. During an interview on March 15, 2021, at 11:00 a.m., FAM-F said ED-A indicated ULPs would be retrained on abuse prevention after C1's incident with ULP-E. Licensee's policy titled, Supervision of Licensed and Unlicensed Personnel, updated November 15, 2019, indicated staff would be supervised to ensure they are performing their job duties competently, consistently, and professionally. The licensee policy indicated staff supervision included implementing additional training. The policy indicated the licensee would provide additional training based on concerns and complaints. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 315		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment	0 325		

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0 325	Continued From page 4 Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of six clients (C1) reviewed was free from maltreatment. C1 was abused. Findings include: On April 15, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish	0 805		

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0 805	Continued From page 5 and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of six clients (C1) reviewed. C1 was roughly handled and yelled at during cares by unlicensed personnel (ULP)-E. The licensee did not report the incident to MAARC immediately as required. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: C1's medical record was reviewed. C1's medical diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, and atherosclerotic heart disease. C1's signed service plan dated March 26, 2020, indicated C1 required assistance with bathing, homemaking, medication administration and safety checks two times per day. C1 used a walker and an electric scooter for mobility. C1's care plan dated July 18, 2019, and signed on March 17, 2020, indicated C1 was assessed as being oriented to person, place, and time. C1 was independent in grooming, toileting, transfers,	0 805		

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0 805	Continued From page 6 ambulation, and escorts, but required assistance with bathing. Fall interventions included use of a call pendant. C1's internal investigation report dated September 21, 2020, indicated on September 20, 2020, during morning medication administration, ULP-E told C1 she would not administer C1's next medication dose at 2:00 p.m. because C1 she could do it on her own. At 2:03 p.m., C1 pressed her call pendant to ask for assistance with medication administration. The report indicated ULP-E answered C1's call at 2:11 p.m., abruptly telling C1 she was turning off C1's call pendant, and C1 needed to get up and get her own medications. C1 reported ULP-E then grabbed and pulled on C1's right wrist trying to get C1 out of bed so C1 could walk over to the medication dispenser located across the room. C1 said she felt weak and was unable to get out of bed. The report indicated ULP-E eventually administered C1's medications. After the incident, director of nursing (DON)-B observed a pink colored bruise approximately 3/4" wide by 1.5" long on C1's right wrist. C1 said she felt unsafe around ULP-E and no longer wanted ULP-E to provide her cares. ULP-E was suspended following further investigation. The report indicated all ULPs would receive education on performance guidelines. Review of the MAARC report, #363761684, dated September 21, 2020, at 8:40 p.m., indicated the date and time of C1's incident occurred on September 20, 2020 at 2:15 p.m. The MAARC report was submitted over 30 hours after the incident occurred. During an interview on March 8, 2021, at 1:00 p.m., DON-B said C1 was a credible reporter and	0 805		

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0 805	Continued From page 7 was alert and oriented. DON-B stated, after her investigation, she concluded C1's accusation was valid. DON-B stated C1's incident involving ULP-E was egregious, and the licensee terminated ULP-E. During an interview on March 8, 2021, at 2:00 p.m., executive director (ED)-A said reporting involving a vulnerable adult (VA) would be brought to DON-B. ED-A said DON-B would be the responsible party for reporting on behalf of the licensee. ED-A said licensee submits MAARC reports on the day of an incident. Review of the licensee policy titled, Vulnerable Adult Reporting and Investigation Policy, updated November 15, 2019, indicated staff who suspected maltreatment should immediately report the incident to the ED. The licensee policy indicated the licensee reported incidents involving VA's to MAARC immediately and no longer than 24 hours from the time an incident occurred. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 805		
0 810 SS=D	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific	0 810		

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0 810	Continued From page 8 measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) for one of six clients (C1) reviewed. After C1 was roughly handled and yelled at during cares by unlicensed personnel (ULP)-E, the licensee failed to update C1's IAPP to identify the abuse C1 sustained from ULP-E; no interventions were added to C1's IAPP to address the abuse. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, and atherosclerotic heart disease. C1's signed service plan dated, March 26, 2020, indicated C1 required assistance with bathing, homemaking, medication administration and safety checks two times per day. C1 used a walker and an electric scooter for mobility. C1's care plan dated July 18, 2019, and signed on March 17, 2020, indicated C1 was assessed	0 810		

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0 810	Continued From page 9 as being oriented to person, place, and time. C1 was independent in grooming, toileting, transfers, ambulation, and escorts, but required assistance in bathing. Fall interventions included use of a call pendant. C1's internal investigation report dated September 21, 2020, indicated on September 20, 2020, during morning medication administration, ULP-E told C1 she would not administer C1's next medication dose at 2:00 p.m. ULP-E told C1 she could do it on her own. At 2:03 p.m., C1 pressed her call pendant to ask for assistance with medication administration. The report indicated ULP-E answered C1's call at 2:11 p.m. ULP-E abruptly told C1 she was turning off C1's call pendant, and C1 needed to get up and get her own medications. C1 reported ULP-E grabbed and pulled on her right wrist trying to get C1 out of bed so C1 could walk over to the medication dispenser located across the room. C1 said she felt weak and was unable to get out of bed. The report indicated ULP-E eventually administered C1's medications. After the incident, director of nursing (DON)-B observed a pink colored bruise approximately 3/4" wide by 1.5" long on C1's right wrist. C1 said she felt unsafe around ULP-E and no longer wanted ULP-E to provide her cares. ULP-E was suspended following further investigation. The report indicated all ULPs would receive education on performance guidelines. C1's IAPP dated June 26, 2020, indicated C1 was assessed as vulnerable for endurance, strength limitations, chronic conditions, pain and disability. C1's IAPP indicated C1 had identified areas of potential vulnerability, and no signs of abuse or neglect. C1's IAPP was not updated after the incident with ULP-E where she sustained bruises	0 810		

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0 810	Continued From page 10 due to ULP-E's conduct. No new interventions were documented on the IAPP to address C1's sustained abuse. During an interview on March 8, 2021, at 1:00 p.m., DON-B stated, after her investigation, she concluded C1's accusation involving ULP-E was valid. DON-B stated C1's incident was egregious, and the licensee terminated ULP-E. During an interview on March 8, 2021, at 2:00 p.m., ED-A said C1 was accurate in her reporting. ED-A said she believed C1 and was not surprised the incident involved ULP-E based on ULP-E's temperament. ED-A said ULP-E's interaction with C1 caused C1 emotional distress. Licensee policy titled, Incident Reporting, updated November 15, 2019, indicated the licensee prevented harm within their scope of their ability to provide care to clients. The licensee's policy indicated the goal is to find and correct the cause of an incident by involving all parties necessary to determine the appropriate outcome. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
01252 SS=E	144A.4798, Subd. 3 Infection Control Program Subd. 3.Infection control program. A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control. This MN Requirement is not met as evidenced by:	01252		

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	H28789	A. BUILDING: _____ B. WING _____	C 03/08/2021

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01252	Continued From page 11 Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. This impacted all of the clients (C2, C3, C4, C5, C6) reviewed. This practice resulted in a level two violation (a violation that did harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings Include: HAND HYGIENE The licensee failed to ensure staff performed hand hygiene per the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) guidelines. The CDC guideline titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, indicated healthcare personnel (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended HCP remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene. The CDC recommended HCP use alcohol-based hand sanitizer (ABHR) with 60% to	01252		

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01252	Continued From page 12 95% alcohol or washing hands with soap and water for at least 20 seconds. Hand hygiene supplies should be readily available to staff. During an observation on March 8, 2021, at 10:45 a.m., unlicensed personnel (ULP)-C entered the apartment of C3 and C4 and performed oxygen saturation and temperature checks for COVID-19 screening. ULP-C did not perform hand hygiene before or after screening C3 and did not wear gloves. ULP-C did not perform hand hygiene before or after screening C4 and did not wear gloves. During an observation on March 8, 2021, at 10:51 a.m., ULP-C entered the apartment of C5 and performed oxygen saturation and temperature checks for COVID-19 screening. ULP-C did not perform hand hygiene before or after screening C5 and did not wear gloves. During an observation on March 8, 2021, at 11:58 a.m., ULP-D entered the apartment of C6 to administer medications. ULP-D dropped a hair accessory on the floor and picked it up with her gloved hands. ULP-D did not change gloves and did not perform hand hygiene before or after administering C6's medications. Licensee's policy titled, Hand Washing Procedure, updated November 15, 2019, indicated the licensee followed the guidelines established by the CDC. The licensee policy indicated staff utilized handwashing and ABHR. The licensee policy indicated hand hygiene is one of the most important ways to prevent the spread of infections. Licensee's policy titled, Gloves-Procedure for Using, updated November 15, 2019, indicated the	01252		

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01252	Continued From page 13 licensee required the use of gloves whenever there may be direct contact between the caregiver and the client. Licensee's policy indicated staff were required to wear gloves during direct contact with clients to prevent the spread of disease and infection. DISINFECTING RESUABLE MEDICAL EQUIPMENT The CDC guideline titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, indicated all non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. During an observation on March 8, 2021, at 10:45 a.m., unlicensed personnel (ULP)-C entered the apartment of C3 and C4 to perform COVID-19 screening. ULP-C used a reusable forehead thermometer and a pulse oximeter. ULP-C did not use disposable coverings or disinfect the forehead therameter and pulse oximeter between and after use with C3 and C4. During an observation on March 8, 2021 at 10:51 a.m., ULP-C entered the apartment of C5 to perform COVID-19 screening. ULP-C used a reuseable forehead thermometer and a pulse oximeter. ULP-C did not use a disposable covering or disinfect the forehead thermometer or pulse oximeter before or after use on C5. During an interview on March 8, 2021 at 10:52 a.m., ULP-C stated he cleaned the reuseable thermometer and pulse oximeter between every one or two clients. ULP-C stated he used hand	01252		

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01252	Continued From page 14 sanitizer to clean the equipment. Licensee policy titled, Disinfecting of Reusable Equipment and Surfaces, updated November 15, 2019, indicated the licensee required reusable equipment to be properly disinfected to destroy disease causing microorganisms. Licensee's policy indicated reusable medical equipment should be immediately disinfected after use with a client. TIME PERIOD TO CORRECT: Seven (7) Days	01252		
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, 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, paragraph (a), clause (4). (b) A person not required to report under the	02015		

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02015	Continued From page 15 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 investigative 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 investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative 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 record review, the licensee failed to immediately report (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of six clients (C1) reviewed. C1 was roughly handled and yelled at during cares by unlicensed personnel (ULP)-E.	02015		

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02015	Continued From page 16 The licensee did not report the incident to MAARC immediately as required. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: C1's medical record was reviewed. C1's medical diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, and atherosclerotic heart disease. C1's signed service plan dated March 26, 2020, indicated C1 required assistance with bathing, homemaking, medication administration and safety checks two times per day. C1 used a walker and an electric scooter for mobility. C1's care plan dated July 18, 2019, and signed on March 17, 2020, indicated C1 was assessed as being oriented to person, place, and time. C1 was independent in grooming, toileting, transfers, ambulation, and escorts, but required assistance with bathing. Fall interventions included use of a call pendant. C1's internal investigation report dated September 21, 2020, indicated on September 20, 2020, during morning medication administration, ULP-E told C1 she would not administer C1's next medication dose at 2:00 p.m. because C1 she could do it on her own. At 2:03 p.m., C1 pressed her call pendant to ask for assistance with medication administration. The report	02015		

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02015	Continued From page 17 indicated ULP-E answered C1's call at 2:11 p.m., abruptly telling C1 she was turning off C1's call pendant, and C1 needed to get up and get her own medications. C1 reported ULP-E then grabbed and pulled on C1's right wrist trying to get C1 out of bed so C1 could walk over to the medication dispenser located across the room. C1 said she felt weak and was unable to get out of bed. The report indicated ULP-E eventually administered C1's medications. After the incident, director of nursing (DON)-B observed a pink colored bruise approximately 3/4" wide by 1.5" long on C1's right wrist. C1 said she felt unsafe around ULP-E and no longer wanted ULP-E to provide her cares. ULP-E was suspended following further investigation. The report indicated all ULPs would receive education on performance guidelines. Review of the MAARC report, #363761684, dated September 21, 2020, at 8:40 p.m., indicated the date and time of C1's incident occurred on September 20, 2020 at 2:15 p.m. The MAARC report was submitted over 30 hours after the incident occurred. During an interview on March 8, 2021, at 1:00 p.m., DON-B said C1 was a credible reporter and was alert and oriented. DON-B stated, after her investigation, she concluded C1's accusation was valid. DON-B stated C1's incident involving ULP-E was egregious, and the licensee terminated ULP-E. During an interview on March 8, 2021, at 2:00 p.m., executive director (ED)-A said reporting involving a vulnerable adult (VA) would be brought to DON-B. ED-A said DON-B would be the responsible party for reporting on behalf of the licensee. ED-A said licensee submits MAARC	02015		

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02015	Continued From page 18 reports on the day of an incident. Review of the licensee policy titled, Vulnerable Adult Reporting and Investigation Policy, updated November 15, 2019, indicated staff who suspected maltreatment should immediately report the incident to the ED. The licensee policy indicated the licensee reported incidents involving VA's to MAARC immediately and no longer than 24 hours from the time an incident occurred. TIME PERIOD FOR CORRECTION: Seven (7) days.	02015		