MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
The Estates at Château LLC

Facility Address:
2106 2nd Avenue South

Facility City:
Minneapolis

State: Minnesota | **ZIP:** 55404 | **County:** Hennepin

Report Number:
H5222070, H5222071, and H5222072

Date of Visit:
May , 31, 2017

Time of Visit:
9:00 a.m to 4:00 p.m.

Date Concluded:
October 23, 2017

Investigator's Name and Title:
Michele Strahan R.N.

☒ **Nursing Home**

Allegation(s):
It is alleged that Resident # 1 was neglected when the facility failed to provide adequate supervision. Resident # 1 was struck with a blunt object at the back of the head by Resident # 2. Resident # 1 suffered a contusion and injury to left eye. Resident # 1 required hospitalization.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

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

Conclusion:
Based on preponderance of evidence the facility failed to provide adequate supervision when Resident #2 assaulted Resident #1. Resident #1 and Resident #2 had four altercations within five days, three of which were within the 24 hours prior to the assault. During the last altercation Resident #2 assaulted Resident #1. Resident #1 went to the hospital and was diagnosed with a broken arm, a swollen left eye, and facial abrasions.

Resident #1 resided in the facility for approximately three and a half months. Resident #1 had diagnoses that included depression, anxiety renal disease, and dependence on dialysis. S/he required minimal assistance of staff for activities of daily living most of the time. S/he was up and around the facility using a wheelchair, and was able to make his/her needs known. Resident #1 had a history of verbal aggression towards other residents. The facility had interventions in place to monitor Resident #1's behavior and redirect him/her.

Resident #2 was admitted to the facility with diagnoses that include depression, anxiety, psychosis, and a below the knee amputation . S/he required the assistance of one staff person for activities of daily living,

was up in wheelchair independently, and was able to make his/her need known. Within the first month at the facility, Resident #2 had six documented resident to resident altercations.

Resident #1 and Resident #2 had a verbal altercation four days prior to the assault. Both residents yelled at each other, used foul language, made threats, and threatened to kill each other. Resident #2 called Resident #1 derogatory racial slurs, and ran at Resident #1 with his wheelchair.

Three days later, during the evening, Resident #1 and Resident #2 were on the patio with several other residents from the facility. Resident #2 had an altercation with another resident and pushed that resident to the ground. Resident #1 told Resident #2 not to treat others in that manner. Resident #1 and Resident #2 began arguing about the interaction that Resident #2 had with the other resident. Resident #2 called Resident #1 derogatory names and spit into Resident #1's face several times. That evening the police were called by an unknown individual. Both residents went back inside the facility and continued to argue. Both residents made threats, yelled at each other, used foul language, and called each other names. Staff were unable to redirect Resident #2 and unable to calm Resident #2. Resident #2 did not want to talk with staff about what happened on the patio. Resident #2 appeared intoxicated and slouched to the left side in his wheelchair. Staff called the police and the police were able to calm Resident #2 and deescalate the situation. Staff placed both residents on fifteen minute visual checks to prevent further incidents. The every fifteen minute visual checks began that morning for Resident #1 at 2:15 a.m., for Resident #2 at 1:45 a.m., and continued for both residents until that night at 11:15 p.m. when Resident #1 was sent to the hospital. There were no changes to either residents' care plans at this time.

The next day, at approximately 11:00 a.m., staff heard Resident #1 and Resident #2 arguing loudly near the nurse's station. Both residents were making accusations about each other, name-calling, and using foul language. Resident #1 informed the staff that he had issues with Resident #2 the evening before, stated that Resident #2 kept coming into Resident #1's room to start arguments, and that Resident #2's arguments were escalating against Resident #1. Resident #1 told two staff members he was afraid of what Resident #2 might do to him. Staff attempted to notify administration during afternoon. Staff did not get a response from administration and continued to monitor both resident with fifteen minute visual checks. There were no changes to either residents' care plans at this time. No new interventions were implemented to protect or keep either resident safe at this time.

That night, at approximately 11:15 p.m., the nurse was called to the unit by a staff person because Resident #2 had assaulted Resident #1. Police were called immediately. Staff found Resident #1 sitting in the hallway in his wheelchair and Resident #1 told staff that s/he was ambushed when s/he got off the elevator. Resident #1's left eye was swollen to the size of a golf ball, a large amount of blood was dripping from his/her face, and his/her left arm appeared deformed. As staff were assisting Resident #1, Resident #2 came out of his/her room yelling that Resident #1 was a liar, parked his/her wheelchair in front of Resident #1, and Resident #1 pulled out a heavy black object wrapped in tape from behind his back and began hitting Resident #2. Staff attempted to separated the residents, the police arrived at that moment, and assisted staff to separate the residents. Staff sent Resident #1 to the hospital for evaluation of his/her injuries. Resident # 2 remained in the facility because he was not seriously injured.

Resident #1 was interviewed and stated that Resident #2 called him names every day such fagot, gay, vicious, and various derogatory racial slurs. Resident #1 stated that Resident #2 hit him first. Resident #1 stated that no nurses were on the floor the evening of the assault for approximately two hours. S/he stated that Resident #2 chased him around the floor for about forty minutes before help arrived. S/he stated that it is a common occurrence to not see staff for extended periods of time.

Resident #2 was interviewed and stated that Resident #1 attacked him. S/he stated that Resident #1 was a bully and sometimes kicked or attempted to throw things at him/her. Resident #2 stated that s/he hurt Resident #1 and sent him to the hospital.

Several staff were interviewed and stated that fifteen minute visual checks of the residents location are completed to confirm that the residents are not together. Staff were unable to recall what the issues Resident #1 and Resident #2 were arguing about during their altercations. One staff person stated that Resident #1 appeared upset after an argument with Resident #2, and Resident #1 stated that Resident #2 was calling Resident #1's mother names. Another staff person stated that Resident #1 was upset that Resident #2 pushed another resident to the ground and after Resident #1 told Resident #2 not to do that, Resident #2 became angry. All staff stated that there was a staff person on the floor with both residents the evening of the assault, and all fifteen minute visual checks were completed. All fifteen minute visual checks were documented for both residents until Resident #1 was sent to the hospital.

The Director of Nursing was interviewed and stated that s/he was not aware of an argument or altercation between Resident #1 and Resident #2 prior to the assault. S/he was not aware that Resident #1 had expressed fear of Resident #2. S/he stated that she would have implemented one to one staffing for the residents to keep them safe.

Hospital records indicated that Resident #1 was diagnosed with a left ulna fracture, left eye swelling, and left eye abrasions. Resident #1 remains in the hospital, and his/her bed hold at the facility expired. Resident #2 remains in the facility.

Police records were reviewed and indicated that Resident #1 and Resident #2 had an altercation at the facility. The residents struck each other with blunt objects, and both residents were injured. Resident #1 was struck in the back of the head, had visible blood, and a left eye contusion. R1 reported that there were no staff on the unit for several hours.

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:

Although the facility had an abuse prevention policy in place to prevent resident abuse, including resident to resident altercations, the facility had no policy related to resident supervision in place. Even though staff were educated on the abuse prevention policy, and staff followed the care plan, this did not prevent Resident #2 from assaulting Resident #1. The facility failed to monitor staff, increase supervision, or implement care plan changes to prevent the assault.

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:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) 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:

hjg

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:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Weight Records
- ☒ Nurses Notes

- [x] Assessments
- [x] Physician Orders
- [ ] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Activities Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records

Other pertinent medical records:

- [x] Hospital Records [x] Ambulance/Paramedics
- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Five.

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:
05/03/2017	2:56 p.m.	06/07/2017	3:08 p.m.	06/19/2017	2:45 p.m.

Interview with family: ○ Yes ◉ No ○ N/A Specify: No working telephone number available.

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: Eight

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Fourteen

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
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ 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 - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Minneapolis Police Department

Hennepin County Attorney

Minneapolis City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	R-C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on 09/21/17, to follow up on deficiencies issued relate to complaint H5222070, H5222071, and H5222072. The Estates at Chataeu LLC is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

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	00937	A. BUILDING: _____ B. WING _____	R-C 09/21/2017

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THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5222070, H5222071, and H5222072. The Estates at Chateau LLC was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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

Electronically Signed | 11/28/17

Minnesota Department of Health

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	00937	A. BUILDING: _____ B. WING _____	R-C 09/21/2017

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245222	A. BUILDING _____ B. WING _____	C 07/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case H5222070, H5222071, and H5222072. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility neglected to supervise, and failed to prevent abuse of two of six residents, (R1 and R2), reviewed when R2 assaulted R1 and then R1 retaliated assaulting R2. R1 was taken to the hospital and diagnosed with a broken arm, a swollen eye, and abrasions near his/her left eye. The assault occurred during the third altercation in 24 hours between R1 and R2. Findings include:	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 223	Continued From page 1	F 223		

R1's medical record was reviewed. R1 was admitted to the facility on 01/18/17. R1's diagnoses included depression, anxiety, end stage renal disease, dialysis, and drug abuse. R1 used a wheelchair for mobility.

R1's plan dated 02/06/17, indicated that R1 was independent with locomotion, required two staff for toileting, and set up assistance for activities of daily living. The care plan indicated that R1 required unspecified monitoring related to complications due to multiple medications and daily use of antidepressants.

The care plan dated 02/28/17, indicated that R1 had incidents of verbal aggression towards other residents. Interventions included, de-escalate, redirect resident from situation, separate R1 from other residents, call for assistance, and notify physician of behaviors that are potentially harmful.

R2's medical record was reviewed. R2 was admitted to the facility 04/12/17. R2's diagnoses included psychosis, depression, and anxiety.

An incident report dated 04/15/17, indicated that during an argument R2 grabbed another resident (roommate) by the head and shook the other resident's head. After the incident staff moved R2's roommate to a new room.

R2's care plan dated 05/01/17, indicated that R2 required the assistance of one staff person for all activities of daily living, and uses a power scooter for mobility. R2 took antidepressants and antianxiety medication.

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F 223	Continued From page 2 An incident report dated 05/09/17, at 4:30 p.m. indicated that R2 and R1 had a verbal altercation and threatened to kill each other. R2 was verbally harassing, and running at R1 with his/her power scooter. R2 called R1 derogatory racial slurs. Both residents were using foul language, making threats, and yelling at each other. Both were placed on 15 minute visual checks for the evening and the night shift. The residents did not touch each other during this altercation. An incident report dated 05/13/17, written at 1:15 a.m., indicated that on the evening of 05/12/17, an unnamed resident pushed another resident to the ground outside on the patio. This resident reported to staff that an unnamed resident had pushed him/her to the ground outside on the patio. The resident that pushed this resident to the ground was not named in the incident report or the nurses notes regarding the incident, dated 05/13/17. There were no changes to this residents care plan and no interventions were implemented to keep this resident, or other residents, safe. An incident report dated 05/13/17 at 1:15 a.m., indicated that R1 and R2 were arguing with each other in the evening of 5/12/17. R1 and R2 were making accusation at each other, name-calling, yelling, and using foul language. R2 refused to discuss an event that took place on the patio where R2 pushed another resident to the ground. R2 appeared intoxicated, the staff were unable to deescalate the situation. Staff called the police and the police de-escalate R2's mood. The facility resumed 15-minute visual checks for the second time on both residents. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No	F 223		

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F 223	Continued From page 3	F 223		

new interventions were implemented to prevent an altercation between R1 and R2.

Nurses' notes dated 05/13/17, at 2:28 p.m., and 2:39 p.m., indicated that R1 and R2 were yelling at each other at the nurse's station and staff directed the residents away from each other. R1 informed staff that he had issues with R2 the evening before, R2 kept coming into R1's room and starting issues, and R2 was escalating issues against R1. R1 appeared tearful and shaky. The notes did not detail the issues. Staff advised both residents to avoid each other. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No new interventions were implemented to prevent an altercation between R1 and R2.

An incident report dated 5/14/17, written at 1:11 a.m. indicated that staff were called to the 4th floor at approximately 11:15 p.m. R2 assaulted R1 with a heavy black object wrapped in tape. Staff found R1 sitting in his wheelchair in the hallway and R1 said, "Look what he did to my eye". R1's left eye was swollen to the size of golf ball, a large amount of blood was dripping from his face, and his left arm appeared deformed. As staff were assisting R1, R2 came out of his room yelling that R1 was lying, parked his wheelchair in front of R1. Then R1 pulled out a heavy black object wrapped in tape from behind his back and struck R2 three times in the back of the head. Staff separated the residents, called the police, and sent R1 to the hospital.

Hospital records dated 05/14/17, indicated that R1 suffered a left ulna fracture, left eye swelling and left eye abrasions. R1 remains in the

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	245222	A. BUILDING _____ B. WING _____	C 07/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(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) COMPLETION DATE
F 223	Continued From page 4 hospital at this time, and his bed hold expired at the facility. During an interview on 05/31/17, at 11:56 a.m., NA-D stated that R2 was verbally abusive to another resident. NA-D stated that the other resident reported that R2 had pushed her/him to the ground on the patio during the evening of 05/12/17, incident report dated 05/13/17, and afterwards R1 and R2 had an argument regarding that incident. At that time R2 spat into R1's face several times. NA-D stated that afterwards R1 and R2 were on 15 minute checks to ensure the safety of both residents, staff visually checked the residents location to confirm that the residents ere not together, document, and sign each check. During an interview on 06/06/17, 11:27 a.m. Licensed Practical Nurse (LPN)-J stated that on 05/13/17, at approximately 11:00 a.m. a staff person called her to assist with an argument between R1 and R2. LPN-J sent R2 to his room and then R1 stated that he was afraid of what R2 might do to R1. LPN-J called the Director of Nursing (DON), left a voice message, and sent a text message regarding R2's statement. LPN-J did not get a return call from the DON. Both residents agreed to avoid each other at that time. Staff continued visual 15-minute checks on both residents. No new interventions were implemented to prevent an altercation between R1 and R2. During an interview on 06/07/17, at 12:52 p.m., DON-M stated that she she was not aware of an altercation between R1 and R2 on 05/13/16, in the afternoon at approximately 11:00 a.m. DON-M stated that she did not receive a voicemail or text from staff regarding R1's	F 223		

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F 223	Continued From page 5 statement of fear after the altercation with R2 during the day at approximately 11:00 a.m. on 05/13/17. DON-M stated that if she had been made aware of an altercation on 05/13/17, in the afternoon she would have made sure that R1 and R2 were safe. DON-M stated that she would have implemented one to one supervision for the residents. The policy titled Abuse Prevention/Vulnerable Adult dated 04/2017, provided by the facility indicated that the policy is to ensure that residents are not subjected to abuse by anyone including other residents, to identify and remedy any abusive situations, and to prevent injuries. The facility has no policy related to supervision of residents.	F 223		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint H5222070, H5222071, and H5222072. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin	2 000		

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2 000	Continued From page 1 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility failed to ensure residents were free from maltreatment for two of six residents, (R1 and	21850		

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21850	Continued From page 2 R2), reviewed when the facility neglected to supervise and prevent abuse. R2 assaulted R1 and then R1 retaliated assaulting R2. R1 was taken to the hospital and diagnosed with a broken arm, a swollen eye, and abrasions near his/her left eye. The assault occurred during the third altercation in 24 hours between R1 and R2. Findings include: The policy titled Abuse Prevention/Vulnerable Adult dated 04/2017, provided by the facility indicated that the policy is to ensure that residents are not subjected to abuse by anyone including other residents, to identify and remedy any abusive situations, and to prevent injuries. The facility has no policy related to supervision of residents. R1's medical record was reviewed. R1 was admitted to the facility on 01/18/17. R1's diagnoses included depression, anxiety, end stage renal disease, dialysis, and drug abuse. R1 used a wheelchair for mobility. R1's plan dated 02/06/17, indicated that R1 was independent with locomotion, required two staff for toileting, and set up assistance for activities of daily living. The care plan indicated that R1 required unspecified monitoring related to complications due to multiple medications and daily use of antidepressants. The care plan dated 02/28/17, indicated that R1 had incidents of verbal aggression towards other residents. Interventions included, de-escalate, redirect resident from situation, separate R1 from other residents, call for assistance, and notify physician of behaviors that are potentially	21850		

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21850	Continued From page 3 harmful. R2's medical record was reviewed. R2 was admitted to the facility 04/12/17. R2's diagnoses included psychosis, depression, and anxiety. An incident report dated 04/15/17, indicated that during an argument R2 grabbed another resident (roommate) by the head and shook the other resident's head. After the incident staff moved R2's roommate to a new room. R2's care plan dated 05/01/17, indicated that R2 required the assistance of one staff person for all activities of daily living, and uses a power scooter for mobility. R2 took antidepressants and antianxiety medication. An incident report dated 05/09/17, at 4:30 p.m. indicated that R2 and R1 had a verbal altercation and threatened to kill each other. R2 was verbally harassing, and running at R1 with his/her power scooter. R2 called R1 derogatory racial slurs. Both residents were using foul language, making threats, and yelling at each other. Both were placed on 15 minute visual checks for the evening and the night shift. The residents did not touch each other during this altercation. An incident report dated 05/13/17, written at 1:15 a.m., indicated that on the evening of 05/12/17, an unnamed resident pushed another resident to the ground outside on the patio. This resident reported to staff that an unnamed resident had pushed him/her to the ground outside on the patio. The resident that pushed this resident to the ground was not named in the incident report or the nurses notes regarding the incident, dated 05/13/17. There were no changes to this residents care plan and no interventions were	21850		

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21850	Continued From page 4 implemented to keep this resident, or other residents, safe. An incident report dated 05/13/17 at 1:15 a.m., indicated that R1 and R2 were arguing with each other in the evening of 5/12/17. R1 and R2 were making accusation at each other, name-calling, yelling, and using foul language. R2 refused to discuss an event that took place on the patio where R2 pushed another resident to the ground. R2 appeared intoxicated, the staff were unable to deescalate the situation. Staff called the police and the police de-escalate R2's mood. The facility resumed 15-minute visual checks for the second time on both residents. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No new interventions were implemented to prevent an altercation between R1 and R2. Nurses' notes dated 05/13/17, at 2:28 p.m., and 2:39 p.m., indicated that R1 and R2 were yelling at each other at the nurse's station and staff directed the residents away from each other. R1 informed staff that he had issues with R2 the evening before, R2 kept coming into R1's room and starting issues, and R2 was escalating issues against R1. R1 appeared tearful and shaky. The notes did not detail the issues. Staff advised both residents to avoid each other. There were no changes to either residents' care plans, and no increased supervision for the safety of either resident. No new interventions were implemented to prevent an altercation between R1 and R2. An incident report dated 5/14/17, written at 1:11 a.m. indicated that staff were called to the 4th floor at approximately 11:15 p.m. R2 assaulted R1 with a heavy black object wrapped in tape.	21850		

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21850	Continued From page 5 Staff found R1 sitting in his wheelchair in the hallway and R1 said, "Look what he did to my eye". R1's left eye was swollen to the size of golf ball, a large amount of blood was dripping from his face, and his left arm appeared deformed. As staff were assisting R1, R2 came out of his room yelling that R1 was lying, parked his wheelchair in front of R1. Then R1 pulled out a heavy black object wrapped in tape from behind his back and struck R2 three times in the back of the head. Staff separated the residents, called the police, and sent R1 to the hospital. Hospital records dated 05/14/17, indicated that R1 suffered a left ulna fracture, left eye swelling and left eye abrasions. R1 remains in the hospital at this time, and his bed hold expired at the facility. During an interview on 05/31/17, at 11:56 a.m., NA-D stated that R2 was verbally abusive to another resident. NA-D stated that the other resident reported that R2 had pushed her/him to the ground on the patio during the evening of 05/12/17, incident report dated 05/13/17, and afterwards R1 and R2 had an argument regarding that incident. At that time R2 spat into R1's face several times. NA-D stated that afterwards R1 and R2 were on 15 minute checks to ensure the safety of both residents, staff visually checked the residents location to confirm that the residents ere not together, document, and sign each check. During an interview on 06/06/17, 11:27 a.m. Licensed Practical Nurse (LPN)-J stated that on 05/13/17, at approximately 11:00 a.m. a staff person called her to assist with an argument between R1 and R2. LPN-J sent R2 to his room and then R1 stated that he was afraid of what R2 might do to R1. LPN-J called the Director of	21850		

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21850	Continued From page 6 Nursing (DON), left a voice message, and sent a text message regarding R2's statement. LPN-J did not get a return call from the DON. Both residents agreed to avoid each other at that time. Staff continued visual 15-minute checks on both residents. No new interventions were implemented to prevent an altercation between R1 and R2. During an interview on 06/07/17, at 12:52 p.m., DON-M stated that she she was not aware of an altercation between R1 and R2 on 05/13/16, in the afternoon at approximately 11:00 a.m. DON-M stated that she did not receive a voicemail or text from staff regarding R1's statement of fear after the altercation with R2 during the day at approximately 11:00 a.m. on 05/13/17. DON-M stated that if she had been made aware of an altercation on 05/13/17, in the afternoon she would have made sure that R1 and R2 were safe. DON-M stated that she would have implemented one to one supervision for the residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		