DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Revere Home

Facility Address:
300 South Main Street

Facility City:
Revere

State: Minnesota | **ZIP:** 56166 | **County:** Redwood

Report Number:
HL00824017

Time of Visit:
12:30 p.m. to 4:15 p.m.
8:30 a.m. to 5:00 p.m.
8:30 a.m. to 4:30 p.m.

Date of Visit:
October 16, 17, and 18, 2017

Date Concluded:
December 11, 2017

Investigator's Name and Title:
William Nelson, RN, Special Investigator
Matthew Heffron, JD, Special Investigator

Type of Facility:

☒ **Other** Boarding Care Home

Allegation(s):

It is alleged that Resident #1 was neglected when the resident was sexually assaulted while in the facility. Resident #1 had asked another resident to help keep Resident #2 away from Resident #1's room because Resident #2 had stated that s/he intended to come to Resident #1's room that night. The other resident gave a note to a staff member indicating Resident #1 was afraid of Resident #2 and needed assistance keeping Resident #2 out of the room, but the staff member threw away the note and took no action. Later that evening, Resident #2 entered Resident #1's room, and engaged in unwanted sexual penetration of Resident #1.

An unannounced visit was made at this facility and an investigation was conducted under:

☒ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

☒ 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 of supervision is substantiated. When the facility received information indicating Resident #1 was afraid of Resident #2, the facility did not take action to prevent an incident from occurring between the residents. Resident #1 and Resident #2 had a sexual interaction, and Resident #2 was criminally charged for the incident.

Resident #1's diagnoses included bipolar disorder and anxiety. The services Resident #1 was receiving from the boarding care home included medication management, meals, appointment coordination, and

transportation to and from appointment and activities.

Resident #2's diagnoses included paranoid schizophrenia and social anxiety. The services Resident #2 was receiving included medication management, meals, appointment coordination, and transportation to and from appointments and activities.

On the day of the incident, Resident #1 approached another resident and stated that Resident #2 was going to come to her room that night, and that she did not want to have sex with him. The other resident agreed to help keep Resident #2 out of Resident #1's room. This other resident subsequently approached a facility staff member and gave the staff member a note stating that Resident #1 was afraid of Resident #2 and needed assistance keeping Resident #2 out of her room. The staff member threw away the original note, but informed the next shift of the concern. The staff station was located so that the door to Resident #1's room could be observed when staff were at the station, and staff monitored the door when they were at the station. However, due to the need to complete other tasks, the staff station was not manned continuously, and there were several short periods of time where the door to Resident #1's room was not monitored. Staff did not contact management or law enforcement regarding the concern. Staff did not approach either Resident #1 or Resident #2 regarding the concern.

The next day, Resident #1 informed a family member, and then facility staff, that Resident #2 had come to her room at approximately 11:30 p.m. and asked to have sexual intercourse. Resident #1 told staff she had not wanted to have sex with Resident #2, but that they did have intercourse, and then Resident #2 had left the room. The family member contacted law enforcement, and Resident #2 was arrested in connection with the incident.

Resident #2 was subsequently charged with third degree criminal sexual conduct and fourth degree criminal sexual conduct. The criminal complaint stated Resident #2 engaged in sexual penetration with Resident #1, who was a vulnerable adult. Resident #2 was also charged with fifth degree criminal sexual conduct in connection with the same incident, with the criminal complaint stating that Resident #2 engaged in nonconsensual sexual contact with Resident #1.

During an interview, Resident #1 stated staff had been warned that Resident #2 had said he was coming to Resident #1's room at a particular time on the night of the incident. Resident #1 stated she was terrified while Resident #2 was in her room, and she did not scream out because she was afraid Resident #2 would harm her if she did.

During an interview, another resident stated s/he heard the incident. This resident stated s/he heard Resident #1 tell Resident #2 "put it in," and that from what s/he heard, believed Resident #1 and Resident #2 then had sex.

During an interview, a direct care staff member stated a resident gave the staff member a note stating Resident #1 was worried that Resident #2 was going to come into Resident #1's room, and that Resident #1 did not want that to occur. The staff member stated s/he then threw the note away but passed on the concern to the next shift. The staff member stated s/he did not speak to Resident #1 about the concern.

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 is responsible for the neglect of supervision. Multiple staff members failed to contact management or law enforcement, or approach the residents involved, or implement any other effective interventions, after receiving information that one resident was afraid of another and wanted assistance preventing an incident from occurring.

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 Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655) - Compliance Not Met
The requirements under State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655) 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] Physician Orders

Other pertinent medical records:

- [x] Hospital Records
- [x] Police Report

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ 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: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Five

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ 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

The Office of Ombudsman for Mental Health and Developmental Disabilities

Revere Police Department

Redwood County Attorney

Revere City Attorney

Redwood County Sheriff's Office

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7015 1660 0000 4149 8297

December 11, 2017

Mr. Robert Cardenas, Administrator
Revere Home
300 South Main
Revere, MN 56166

Re: Enclosed State Boarding Care Home Licensing Orders - Project Numbers HL00824017 and HL00824018

Dear Mr. Cardenas:

The above facility survey was completed on November 16, 2017 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules and to investigate complaint numbers HL00824017 and HL00824018. At the time of the survey, the investigator from the Office of Health Facility Complaints, Minnesota Department of Health, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Attn: Matthew Heffron, 85 East 7th Place, PO Box 64970, Saint Paul, MN 55164.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

Please note 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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Supervisor, Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4221 Fax: 651-281-9796

Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00824	A. BUILDING: _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVERE HOME	300 SOUTH MAIN REVERE, MN 56166

(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
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME 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 complaints #HL00824017 and HL00824018. The following correction orders are issued. Minn. Rule 4655.9000, subpart 1 is issued in	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes and rules.	

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3 000	Continued From page 1 relation to HL00824018. Minn. Stat. 144.651 Subd 14. is issued in relation to HL00824017. Minn. Rule 4660.7800, subpart 1 is issued in relation to HL00824018. Minn. Rule 4660.7800, subpart 2 is issued in relation to HL00824018. Minn. Rule 4660.7800, subpart 5 is issued in relation to HL00824018.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
31455	MN Rule 4655.9000 Subp. 1 Housekeeping; General Requirements Subpart 1. General requirements. The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited.	31455		

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31455	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview the facility was maintained in a clean and sanitary manner for 15 of 15 residents reviewed (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, and R15).. Findings include: During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in client bedrooms 2, 3, 4, 6, 7, 9, 10, and 11 that the overhead lights did not have a globe or cover over the light bulbs. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the men's common bathroom and shower room, that the overhead lights did not have a globe or cover over the light bulbs. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the women's common bathroom and shower room that the overhead lights did not have a globe or cover over the light bulbs. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the women's common bathroom and shower room that there were missing tiles by the tub, toilet, and door. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the female bathroom next to bedroom #12 that the overhead lights did not have a globe or cover over the light bulbs. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the female bathroom next to	31455		

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31455	Continued From page 3 bedroom #12 that the toilet tank did not have a cover on the top of it. Interview of staff and clients indicated that this had been missing for at least a year. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the bathroom accross from the laundry room that the overhead lights did not have a globe or cover over the light bulbs. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the client bedroom #12 that there was a strong odor present. Staff present were asked about this and they reported that this is common in this room. The room is adjacent to a bathroom that had been flooded multiple times. This resulted in the bedroom being flooded by the toilet water. The director was interviewed regarding the smell of this room, and she acknowledged the strong odor and the potential concern of mold in the walls and floors. She stated that she would research the ways to investigate for mold inside walls and under flooring. The flooring is a laminate floating floor according to the director of the program. During a facility tour on October 18, 2017 at 1:00 p.m. it was noted in bedroom #6 that the privacy curtain rails had been pulled down off the brackets on the left side, and they were duct taped together to hold them up. They were several inches lower than the curtains on the right side of the room and could not be opened completely. During a facility tour on October 18, 2017 at 1:00 p.m. it was noted that the mattress in bedroom #7 was torn, the mattresses in bedroom #2 bed #1, bedroom # 4 bed #2, bedroom # 9, and bedroom #11 bed #1 all had areas of the protective vinyl	31455		

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31455	Continued From page 4 outer layer worn thin and cloth could be seen where the protective coating had been. SUGGESTED METHOD FOR CORRECTION: The administrator and house manager could work with maintenance to implement needed repairs. The administrator and house manager could develop a system for routine assessment of repair needs within the facility. TIME PERIOD FOR CORRECTION: Thirty (30) days.	31455		
31850	MN Rule 144.651 Subd. 14 Patients & Residents of HCF 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 nontherapeutic 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 nontherapeutic 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 document review, the facility failed to ensure residents were free from maltreatment (neglect), for two of two residents reviewed, when staff were informed R1 believed	31850		

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31850	Continued From page 5 R2 would enter her room for sex during the night, R1 requested assistance preventing this from occurring, and staff did not take reasonable measures to prevent the incident from occurring. As a result, R1 and R2 had sex, and R2 was arrested for criminal sexual conduct. Findings include: R1's medical record was reviewed. R1's diagnoses included bipolar disorder and anxiety. The services R1 was receiving from the boarding care home included medication management, meals, appointment coordination, and transportation to and from appointment and activities. R2's medical record was reviewed. R2's diagnoses included paranoid schizophrenia and social anxiety. The services R2 was receiving included medication management, meals, appointment coordination, and transportation to and from appointments and activities. Review of a document titled Monthy Summary, with an entry dated September 24, 2017, indicated staff informed R1 that the facility policy was that there should not be sexual relationships between residents. Review of the nurse's notes for R1 and R2, dated October 5, 2017, do not contain any entry regarding R1 having concerns that R2 would enter her room, or any documentation regarding contact with management or law enforcement, or any new interventions implemented for either R1 or R2. Review of a nurse's note for R1, dated October 6, 2017, at 9:25 p.m., indicated three different	31850		

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31850	Continued From page 6 residents informed staff that R1 had said R2 sexually assaulted R1. Staff stated that unless R1 reported it herself, there was nothing they could do about it. R1 did subsequently come to the staff member, and reported R2 had entered R1's room the night before and requested sex. R1 stated she wanted to tell R2 "no," but did not. A subsequent page of the nurse's note, undated, indicated R1 stated she gave in and acted like she liked it, so that R2 would not hurt her. The staff member responded that she had previously told R1 and R2 to stay away from each other. Review of a nurse's note for R1, also dated October 6, 2017, at 9:00 p.m., indicated R1's mother had called law enforcement, and law enforcement responded to the facility and spoke with R1. Review of a nurse's note for R2, dated October 6, 2017, at 9:35 p.m., indicated staff went to R2's room and asked him what occurred with R1. R2 stated he went to R1's room, asked if R1 wanted to have sex, and R1 said yes. An entry dated October 6, 2017, at 11:45 p.m., indicated R2 was removed from the facility by law enforcement. Review of a nurse's note for R1, dated October 7, 2017, at 8:30 a.m., indicated R1 told staff that R2 came to her room at midnight. R1 stated that R2 had said earlier in the day that he was going to come at midnight. R1 stated she did not tell R2 not to come, but that she told other residents she did not want R2 to come. Review of a nurse's note for R1, dated October 8, 2017, indicated another resident, who was in R1's room at the time of the incident, told staff she had heard R1 verbally agree to the sexual interaction with R2.	31850		

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31850	Continued From page 7 Review of a criminal complaint, dated October 9, 2017, indicated R2 was charged with third degree criminal sexual conduct and fourth degree criminal sexual conduct. The criminal complaint stated R2 engaged in sexual penetration with R1, who was a vulnerable adult. R2 was also charged with fifth degree criminal sexual conduct in connection with the same incident, with the criminal complaint stating that R2 engaged in nonconsensual sexual contact with R1. During an interview on October 17, 2017, R1 stated staff had been warned that R2 had said he was coming to R1's room at a particular time on the night of the incident. R1 stated she was terrified while R2 was in her room, and she did not scream out because she was afraid R2 would harm her if she did. During an interview on October 17, 2017, R3 stated that R1 approached him/her during the day on October 5, 2017, and stated R2 intended to enter her room around midnight. R3 wrote a note indicating R1 was concerned about this and gave it to a staff member. During an interview on October 17, 2017, at 3:00 p.m., nursing aide (NA)-A stated that on October 5, 2017, R3 gave her a note which stated that R2 was going to enter R1's room and that R1 did not want R2 to do so. NA-A stated she threw the note away, but informed the next shift of the concern. NA-A stated she did not approach R1 about R1's concern. NA-A stated that the following day, R1 called R1's family member, and the family member then called law enforcement and the facility. SUGGESTED METHOD FOR CORRECTION:	31850		

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	00824	A. BUILDING: _____ B. WING _____	C 11/16/2017

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31850	Continued From page 8 The facility could develop policies for addressing resident safety concerns, including when to report resident concerns to management and/or emergency services. The facility could educate staff members on appropriate reporting of resident concerns. TIME PERIOD FOR CORRECTION: Thirty (30) days.	31850		
34640	MN Rule 4660.7800 Subp. 1 Plant Operation & Maint. Existing/New Constr Subpart 1. General requirements. The physical plant shall be kept in a continuous state of good repair and operation with regard to the health, comfort, safety and well-being of the occupants in accordance with an established routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to have an established routine maintenance and repair program. Findings include: On the days of the site visit, there were 15 clients being served by the facility. An interview with the director of the program confirmed that there were no maintenance staff to perform routine maitenance on the physical plant equipment and to address the routine and emergent repair of items on an as needed basis. The director of the program estimated that there has not been a maintenance person for	34640		

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34640	Continued From page 9 approximately three years. The director of the program did not have a maintenance plan or schedule. An interview with multiple staff confirmed that the process to address emergent and non-emergent repairs was to inform the director of the program either in writing or verbally of the repair need. The staff stated that they did what they could but that they were not electricians, plumbers, or roofers. SUGGESTED METHOD FOR CORRECTION: The administrator and house manager could work with maintenance to implement needed repairs. The administrator and house manager could develop a system for routine assessment of repair needs within the facility. TIME PERIOD FOR CORRECTION: Thirty (30) days.	34640		
34645	MN Rule 4660.7800 Subp. 2 Plant Operation & Maint. Existing/New Constr Subp. 2. Walls, floors, and ceilings. Walls, floors, and ceilings shall be kept in good and acceptable repair at all times. They shall be of a type or finish to permit good maintenance including frequent washing, cleaning, or painting. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure ceilings and floors remained in good repair. This had the potential to affect 15 of 15 residents who resided in the facility. Findings include:	34645		

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34645	Continued From page 10 During the physical plant tour on 10/16/2017, at 2:15 p.m. the following concerns were observed: Resident rooms 7, 8, and 9 were noted to have a heavily stained carpet with multiple large dark spots that appeared as if there had been food and beverages spilled on it. These were the only three rooms with carpeting used for a flooring surface. The ceiling in the hallway of the client room area had multiple water spots. One area is approximately 4 feet by 2 feet, in front of client room 6. The ceiling is brown from and the paint had been scrapped off. Client room # 4 had no baseboard around the entire room. The female bathroom ceiling had water stains on it, staff reported water came through the ceiling light fixure during rain storms. The staff bathroom ceiling had water stains on it, the staff reported water came through the ceiling light fixure during rain storms. The laundry room ceiling had multiple water stains on it. The hallway by the nursing station had water stains and the stucco/paint was bubbling out at the ceiling/wall intersection. The kitchen floor was in poor repair. Multiple tiles were chipped on the edges and corners.There were several tiles missing from the floor with black open areas left in the tiles place. There were three areas of tiles taped down, the tape	34645		

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34645	Continued From page 11 was dirty, some of the tape edges had rolled up and collected dirt. SUGGESTED METHOD OF CORRECTION: The administrator and house manager could work with maintenance to implement needed repairs. The administrator and house manager could develop a system for routine assessment of repair needs within the facility. TIME PERIOD FOR CORRECTION: Thirty (30) days.	34645		
34660	MN Rule 4660.7800 Subp. 5 Plant Operation & Maint. Existing/New Constr Subp. 5. Electrical wiring and appliances. Electrical wiring, appliances, fixtures, equipment, and cords shall be maintained in a serviceable and safe condition. Light and power panels shall be properly indexed and locked when necessary. Radios, televisions, lamps, or clocks shall not be placed within reach of sanitary fixtures. This MN Requirement is not met as evidenced by: The facility failed to maintain a safe environment by failing to keep electrical wiring for light fixtures and light switches/outlets covered and light fixtures secured against the wall. One of the lights affected was in the men's bathroom, affecting 12 out of 15 residents. Findings include: During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in client room 8 that a wall light box with wires in it did not have a light attached to	34660		

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34660	Continued From page 12 it nor was it covered. The wires were capped but exposed. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the men's bathroom that the wall light above the sink was hanging by the wires over the sink. The staff person stated s/he did not know how long it had been like that but s/he did not recall it being like that the day before. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in room 11 bed 2 that the wall light above the client's head of the bed was hanging by the wires. The resident was not present at the time. The staff member did not know how long the light had been like that. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in room #4 the light switch by the door did not have a cover on it. The outlet below the lightswitch did not have an outlet cover. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in room #3 bed #1 the wall light above the resident's head of the bed had no light bulb, was loose and no pull chain. The resident said that the light has not been functional since she arrived, and demonstrated that the light moved around very easily when touched. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in the exercise room/TV room that a large black wire was hanging down across the room, where clients and staff walk to get to the TV area. During a facility tour on October 16, 2017 at 2:30 p.m. it was reported by staff that the kitchen light in the preparation area did not work properly after rain water poured out where the light meets the	34660		

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34660	Continued From page 13 ceiling. The light was a fan at one time, however the blades were removed and the light kit below the fan motor was being used as the preparation area light. The light bulbs were not covered. The regulations state the light bulbs in food preparation areas must be covered. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in room 3 that the heating register was approximately three inches from the wall and the anchor bolts were visible and pulling out of the wall. During a facility tour on October 16, 2017 at 2:30 p.m. it was noted in room 6 that the heating register was approximately three inches from the wall and the anchor bolts were visible and pulling out of the wall. SUGGESTED METHOD OF CORRECTION: The administrator and house manager could work with maintenance to implement needed repairs. The administrator and house manager could develop a system for routine assessment of repair needs within the facility. TIME PERIOD FOR CORRECTION: Thirty (30) days.	34660		