Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			**Report Number:**	**Date of Visit:**
Revere Home			HL00824021	June 6, 2018
Facility Address:			**Time of Visit:**	**Date Concluded:**
300 South Main			11:00 am to 4:15 pm	August 10, 2018
Facility City:			**Investigator's Name and Title:**	
Revere			Kathleen Smith, DNP, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	56166	Redwood		

☒ **Other** Boarding Care Homes

Allegation(s):

It is alleged Client #1 and Client #2 were neglected when staff failed to provide adequate supervision that resulted in Client #2 grabbing Client #1 under his/her arms and pushed Client #1 into the wall.

☒ 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 the evidence the allegation of neglect of supervision is substantiated. The boarding care home failed to ensure the safety of Client #1 when Client #2 grabbed the client and held her against the wall. Additionally, during the on-site investigation it was discovered another client, Client #3 had fallen off the roof while completing work for the boarding care home.

All three clients received services in the co-ed boarding care home, and are their own representatives. According to interviews with Client #1 and Client #2, initially, there was a verbal altercation with Client #2 calling Client #1 names and vice versa. Client #2 told Client #1 to stop and when Client #1 stepped into Client #2's personal space, this is when Client #2 grabbed her and pushed her against the wall. Staff and clients verbally attempted to separate the two clients and finally one client was able to persuade Client #2 to let go of Client #1. Staff spoke with both clients and they went to their respective rooms. During interviews both clients confirmed the altercation occurred and they are now speaking to one another. Staff did not contact law enforcement at any time during the physical altercation or after the incident.

During an interview it was revealed Client #3 fell off the roof while completing work for the boarding care home. During an interview it was revealed the clients had previously completed work for the boarding care home for something to do and were not compensated. Client #3 and Client #4 during interviews stated they

had volunteered to complete the work. An interview with a staff member revealed the clients had permission to be on the roof, however there was nobody out there with them. This staff member stated Client #4 came off the roof and let staff know to call for an ambulance as Client #3 had fallen off the roof. Client #3 was taken for evaluation, and returned to the home. Two days later due to increased pain Client #3 returned to the hospital and it was discovered the client had three broken ribs. There is no documentation of the incident or follow up in Client #3's medical record.

Boarding care staff were aware the clients were on the roof, however there was no one out with them, as there were only two staff working. Staff contacted emergency services and the director regarding both incidents. An incident report was received for the fall from the roof, but not for the grabbing incident. None of the above allegations or incidents were reported to the Common Entry Point.

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:

Click Here and Type

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 does not have a sufficient safety or reporting plan. Additionally, staff are not trained to deescalate situation or manage behaviors in the population being served.

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 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 for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not

met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

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: Four

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: ______

Tennessen Warnings

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: Two

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:

- [x] Personal Care
- [x] Infection Control
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Meals
- [x] Facility Tour

Was any involved equipment inspected: ( ) Yes ( ) No (•) N/A

Was equipment being operated in safe manner: ( ) Yes ( ) No (•) N/A

Were photographs taken: ( ) Yes (•) No Specify: ______

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Mental Health and Developmental Disabilities

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 **08/06/2018**

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 compliant investigation was a conducted to investigate #HL00824021. The following correction orders are issued.	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/rules for Nursing Homes.	

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

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 08/06/2018

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	Continued From page 1	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 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.	
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	31850		

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 08/06/2018

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
31850	Continued From page 2	31850		

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 document review and interview, the boarding care home failed to ensure the safety and well being of one of two residents (C1, C2), while working on the facilities roof.

The findings include:

C1 and C2 resided in the boarding care facility and are their own representatives. Progress notes were requested for C1 and C2 however, these documents were not received.

An Incident/Accident Report dated June 1, 2018, indicated C1 was given permission to be on the roof. Furthermore the document indicated C1 fell off the roof, C2 informed staff to call an ambulance, and staff found C1 on the ground attempting to get up. The document also revealed C1 had an abrasion on the left shoulder and left side of the face, and was conscious. There was no follow up documentation or assessment of C1 after the fall.

During an interview with C1 on June 6, 2018, it was stated C1 volunteered to help repair the roof and there was no exchange of services or money. C1 stated he had two cracked ribs and had hit the window air conditioner. During an interview on the same day, C2 stated C1 fell off the roof and

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 08/06/2018

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
31850	Continued From page 3 he helped him. An interview with the owner on July 18, 2018, at 2:55 pm, revealed C1 and C2 had assisted in the past when the roof was leaking and C2 had experience in this area. Both residents volunteered when the roof began to leak in another area. The owner was made aware of the injury after the incident. An interview with Unlicensed Personnel (ULP-4), on July 27, 2018, at 9:38 am, revealed both residents were allowed to be on the roof, they got on the roof by ladder, and there was no-one else out there with the clients. ULP-4 stated C1 had been unconscious initially and did not know what happened, then he was able to state his name and knew his location. C1 was assisted back into the facility through the window, vital signs were taken and not documented. Emergency services were contacted and took C1 to the hospital. This staff member believed C1 hit the air conditioner because it was dented. ULP-4 also stated two days later, C1 returned for follow up due to increased pain and it was determined C1 had three cracked ribs. Review of a policy and procedure document without a date revealed the boarding care facility will take steps to prevent maltreatment. SUGGESTED METHOD FOR CORRECTION: The facility could implement a policy regarding safety assessments for resident activities, including ensuring that activities are appopriate for residents. The facility could then monitor compliance with this policy. In addition, the facility could contract facility maintenance rather than letting residents complete repairs.	31850		

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 08/06/2018

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
31850	Continued From page 4 TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	31850		
31995	MN Rule 626.557 Subd. 4A Reporting Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on document review and interview, the boarding care provider failed to report an incident of client injury to the Common Entry Point (CEP), when a resident (C1) fell off the roof while working on the facility's roof. The findings include: C1 resided in the boarding care facility and is his own representative. An Incident/Accident Report dated June 1, 2018, indicated C1 was given permission to be on the roof. Furthermore the document indicated C1 fell off the roof and another client informed staff to call an ambulance, and staff found C1 on the ground attempting to get up. The document also revealed C1 had an abrasion on the left shoulder and left side of the face and was conscious. There is no follow up documentation or	31995		

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 08/06/2018

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
31995	Continued From page 5 assessment of C1 after the fall. A copy of the CEP was requested and was not produced. During an interview with C1 on June 6, 2018, it was stated C1 volunteered to help repair the roof and there was no exchange of services or money. C1 stated he had two cracked ribs and had hit the window air conditioner. An interview with the owner on July 18, 2018, at 2:55 pm, revealed C1 and another client had assisted in the past when the roof was leaking. Both clients volunteered when the roof began to leak in another area. The owner was made aware of the injury after the incident. An interview with Unlicensed Personnel (ULP-4), on July 27, 2018, at 9:38 am, revealed both clients were allowed to be on the roof, they got on the roof by ladder and there was no-one else out there with the clients. ULP-4, stated C1 had been unconscious initially and did not know what happened, then he was able to state his name and knew his location. C1 was assisted back into the facility through the window, vital signs were taken and not documented. Emergency services were contacted and took C1 to the hospital. This staff member believed C1 hit the air conditioner because it was dented. ULP-4 also stated two days later C1 returned for follow up due to increased pain and it was determined C1 had three cracked ribs. ULP-4 went on to say the director was contacted and ULP-4 was told to complete an incident report. Review of a policy and procedure document without a date revealed the boarding care facility will take steps to prevent maltreatment.	31995		

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 08/06/2018

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
31995	Continued From page 6 SUGGESTED METHOD FOR CORRECTION: The facility could review the its policy on reporting maltreatment and update it to reflect the requirement to do so. The management could conduct training on reporting of possible maltreatment with all staff. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	31995		