DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Colony Court

Facility Address:
200 22nd Avenue NE

Facility City:
Waseca

State: Minnesota

ZIP: 56093

County: Waseca

Report Number:
HL20207003 and HL20207004

Date of Visit:
August 10, 2017

Time of Visit:
10:00 a.m. to 6:30 p.m.

Date Concluded:
March 9, 2018

Investigator's Name and Title:
Meghan Schulz, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the alleged perpetrator failed to provide adequate care to the client, left the client on the toilet unattended. The client had a fall and a right hip fracture.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

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

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect is substantiated. The facility failed to assess the client after an earlier fall and hospitalization. The facility also failed to update the client's service plan, left the client alone on the toilet, which resulted in a fall with hip fracture. The facility also failed to conduct a comprehensive assessment or initiate new interventions when the client returned from the post-hip fracture hospitalization, and failed to initiate emergency care when the client continued to decline.

The client received services from a provider licensed as a comprehensive home care provider. The client had a diagnosis of dementia and received assistance with toileting, repositioning, and bathing.

The client suffered a previous hip fracture three months prior to the hip fracture described in the allegation. After the first hip fracture, the client did not have an updated assessment. A progress note by a nurse indicated a personal alarm system was added to the client to help notify staff when the client was trying to get up unassisted. The client's admission assessment indicated the client was independent with toileting and transferring. There were no subsequent assessments in the client's chart indicating a change in status. However, interviews and review of other documents indicated the client required extensive assistance from staff, including that a mechanical lift was being used at times.

On the date of the hip fracture in the allegation, the client was left alone on the toilet while the alleged perpetrator (AP) went to grab gloves down the hallway. When the AP returned, the client was on the floor. The AP went downstairs to get assistance to help the client off the floor because no other staff members were in the memory care unit. A progress note in the chart indicated the client was complaining of hip pain the evening after the fall. The next morning, the registered nurse (RN) assessed the client and received an order for a portable x-ray, which showed the client had a hip fracture. The RN sent the client to the hospital, where the client was admitted for about a week and required surgery.

The client returned from the hospital with a significant change in condition. The nursing staff and family discussed starting the client on hospice care and the medical provider was updated on the status of the client. The client died the next day, approximately two hours after the hospice discussion, with family at the bedside. The client was not on hospice at the time of the death. The client's record indicated the client's code status was for cardiopulmonary resuscitation (CPR) to be performed, however CPR was not performed, and emergency medical services were not contacted.

During an interview, multiple direct care staff stated that there was not a good way to call people for assistance. The staff indicated the way they call for assistance was to turn the bathroom cord or the client pendant on and off until someone recognized the need to come to that area. Not all the clients had pendants and pull cords were only in the bathroom. Multiple direct care staff were unable to show where the client's level of assistance was in the chart and stated they know what each client needs by "word of mouth" from other staff. Training records indicated the education given to staff did not address what staff should do in the event of a fall or how to assess a client after a fall. No training was received related to use of the personal alarm system. The facility failed to do a fall risk assessment on the client even though their education modules stated they do them.

During an interview, a registered nurse (RN) stated that she was notified by the AP on the evening of the fall, but was told the client did not have any pain. The RN stated the client had pain on his/her assessment the morning after the fall. The RN obtained a portable x-ray order from the provider and sent the client to the hospital after the discovery of the fracture. The RN stated that services were added for the client but there was not always time to get out the paper to update the assessments. An RN stated that the facility CPR policy indicated that facility staff do not perform CPR. The RN stated family did not want 911 called and that hospice was agreed upon.

During an interview, a family member stated that the client had sustained multiple hip fractures while at the facility and that the family was never told that the client needed a different level of care. The family member stated they did not expect CPR to be performed on the client.

During an interview, the medical doctor (MD) stated the hip fracture was likely a contributing factor in the client's death. The MD was not aware of the client's code status.

During an interview, the AP admitted to leaving the client alone on the toilet in order to go grab gloves down the hallway The AP stated s/he did not think that the client would get off the toilet on his/her own.

The AP stated that s/he got help and called the on-call RN and informed her of the client's status. AP stated s/he does not remember if the client was in pain after the fall.

The death record indicated the manner of death was accidental and the cause of death was from complications from the hip fracture and fall.

Although requested, the facility did not provide a policy or protocol related to falls, non-hospice deaths, CPR, assessments, or service plans that were in effect prior to the date of the onsite investigation. The facility has begun to develop policies after the date of the on-site investigation.

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 did not have up to date assessments and service plans for client indicating the current needs of the client. The facility failed to have a system in place where staff could easily call for assistance The facility failed to have policies in place for staff to follow. Multiple staff were only aware of what cares to do for client by word of mouth because the facility failed to have procedures in place to ensure staff were aware of what services to provide to clients.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

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

Additional facility records:

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

Number of additional resident(s) reviewed: Three

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: client is deceased

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: Client is deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

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:

☒ Wound Care
☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Restorative Care
☒ Transfers
☒ Meals
☒ Facility Tour
☒ Injury
☒ Incontinence

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 Long-Term Care

Waseca County Medical Examiners

Waseca Police Department

Waseca County Attorney

Waseca City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20207	A. BUILDING: _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On August 10, 2017, a complaint investigation was initiated to investigate complaints #HL20207003 and #HL20207004. At the time of the survey, there were 57 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on document review, observation, and interview, the licensee failed to ensure the right of one of one client (C1) reviewed to be free from maltreatment. C1 was neglected when the facility failed to assess C1 after an earlier fall and hospitalization, failed to update C1's service plan, left C1 alone on the toilet resulting in a fall with hip fracture, failed to conduct a comprehensive assessment or initiate new interventions when C1 returned from the post-hip fracture hospitalization, and failed to initiate emergency care when C1 continued to decline. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to a serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one of a limited number of staff are involved or that a situation has occurred only occasionally). Findings include: C1's record was reviewed. C1 had a diagnosis of Parkinson's disease, osteoporosis, and dementia and received comprehensive home care services including assistance with toileting, repositioning, and bathing according to service plan dated April 16, 2016. C1 was admitted to the facility on June 19, 2015. C1's initial assessment on June 14,	0 325		

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0 325	Continued From page 2 2015 stated the client was independent with mobility and toileting, and no other assessment indicated a change in toileting or mobility. The client suffered a left hip fracture on March, 11, 2017, and returned from the hospital on March 17, 2017. The facility failed to assess C1 after her return. According to progress note on March 20, 2017, C1 suffered a fall out of bed with no injury indicated. A progress note on March 20, 2017 from registered nurse (RN)-B states an alarm system was implemented to notify staff when C1 tried getting up without assistance. The facility had no alarm system policy and no records of training regarding the system for staff. The alarm system was not on C1's service plan. On June 27, 2017 a progress note written by PCA-I states C1 was taken "to the bathroom at 8:45 p.m. and she was sitting on the toilet. Staff went to get gloves and before I returned she stood up and fell on the floor. Both staff had to get her up off the floor. Seems to be ok, did say her leg hurt. Will watch her and check on her." On June 28, 2017 a progress note written by DON-A states that C1 was showing signs of pain and the provider was notified and a portable x-ray was obtained. The x-ray showed a right femur fracture and the client was sent to the hospital on June 28, 2017. Hospital records indicate the client was admitted to the hospital on June 28, 2017 with a right hip fracture that required surgical intervention. Hospital records state client was nonverbal for her entire stay in the hospital. The client was discharged back to the facility on July 5, 2017. On July 5, 2017 the client returned from the	0 325		

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0 325	Continued From page 3	0 325		

hospital and per note in the provider communication record, at 11:45 a.m. DON-A stated that C1 returned from the hospital and was "very pale" and had thick clear secretions coming from her mouth continually. A note written by medical doctor (MD)-D written at 4:21 p.m. acknowledged the update from DON-A and stated to encourage deep breathing and let them know of any further concerns with respiratory status.

On July 6, 2017 there is a note in the provider communication record at 12:44 p.m. from DON-A stating that C1 had a significant change in status and that she was not responding to physical or verbal stimuli. DON-A stated in the note s/he spoke with C1's power of attorney, who agreed to a hospice admit. The provider responded at 12:48 p.m. on July 6, 2017 and stated "agree with your plan for hospice eval." According to the communication log, the provider was notified at 4:15 p.m. that C1 had passed away at 2:40 p.m. on July 6, 2017.

A progress note from RN-B at 10:39 p.m. on July 6, 2017, stated that she was asked to check on C1 at 2:40 p.m. as staff were concerned that C1 passed away. The progress note by RN-B stated "listened to chest for a heartbeat for a full minute and was unable to hear one. Writer checked for cartoid pulse on both sides of neck and again was unable to locate a pulse. Writer felt for pulse on both wrists and was unable to locate a pulse. Writer then again listened to chest and lungs and was unable to find either. At 2:45 p.m. this writer informed family she had passed away. Non-Hospice protocol was followed." The client was not on hospice at the time of death. C1's resident profile, listed C1's code status as CPR, but CPR was not performed, and emergency

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0 325	Continued From page 4 medical services were not contacted. The death record indicated the client died on July 6, 2017, the manner of death was accidental, and the cause of death was from complications from the femur fracture and the fall. During an interview on August 10, 2017 at 3:23 p.m., personal care assistant (PCA)-C stated that she was the other assistant working with PCA-I in the memory care unit the evening C1 fell. PCA-C stated she was downstairs talking to another staff member when she was notified of C1's fall. PCA-C states PCA-I left the memory care unit to come downstairs and find PCA-C to let her know that C1 had fallen and she needed help getting her off the floor. PCA-C states that C1 had a clip alarm on, and that anyone with an alarm on should not have been left alone. PCA-C also stated that after the fall, C1 was complaining of hip pain, and that the on call nurse was notified of the fall that evening. PCA-C states that the bathroom cord was how staff call for help, but that PCA-I left the bathroom to go get help. During an interview on August 10, 2017 at 4:00 p.m., the director of nursing (DON)-A stated that she received a call from PCA-I the evening of C1's fall. DON-A stated she was told that PCA-I left C1 alone on the toilet while she ran to get gloves. DON-A stated she was not told that C1 was in pain after the fall. Staff were able to transfer the client off the floor and back to bed. DON-A stated the next morning when she assessed C1, she saw a lot of swelling on the left hip, so she called MD-D who gave an order for a portable x-ray, which showed a fracture. C1 was transferred to the hospital. DON-A stated they were using a TABS alarm on C1 prior to the fall and an assist of one person for transfers. DON-A	0 325		

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0 325	Continued From page 5 stated when C1 returned from the hospital they did not get a call from the hospital, C1 just showed up in the hallway with a ride service company driver (D)-E. DON-A stated C1's condition was not normal when she returned, and that C1's condition was alarming, C1 was cold to the touch, C1 had saliva coming out her mouth, and C1 was pale and grey colored. DON-A stated they got C1 settled in and called the physician about her condition. DON-A stated that the client returned on July 5, 2017 and on July 6, 2017 had a significant change in condition in which the physician was notified and hospice was discussed. DON-A stated the family did not want 911 called and that they agreed on hospice for C1. DON-A stated the client was not on hospice at the time of her death and they followed the non-hospice protocol and called 911 after her death. DON-A states she did not do an updated assessment on C1 after the change in condition because there was not always time to get out the paper to do it. During an interview on August 14, 2017 at 2:10 p.m., registered nurse (RN)-B stated she was not familiar with a falls policy for the facility. RN-B states DON-A primarily works with the memory care clients, which is where C1 resided. RN-B stated that when C1 came back from the hospital after her hip fracture, she was pale, had drool coming from her mouth, was only minimally responsive, and was full of feces, and stated this was not normal for C1. RN-B states DON-A and herself assessed C1, put her to bed, and contacted the doctor. RN-B states that the client had already passed away before hospice came out to assess her, and that C1 was not on hospice at the time of her death. RN-B was unable to recall or find C1's code status in the chart, but stated that they would not have done	0 325		

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0 325	Continued From page 6 cardio pulmonary resuscitation (CPR) on C1 because they do not perform CPR at the facility. During an interview on September 7, 2017 at 2:24 p.m., PCA-I stated she left C1 on the toilet to run and get gloves down the hallway, and she did not think C1 was going to try and get up off the toilet. PCA-I stated before the incident, gloves were kept in the hallway, now they are kept in the client's rooms. PCA-I stated that there was not a good way to call people for help. PCA-I stated when she found C1 on the floor, she went downstairs to find someone to help get C1 up. PCA-I stated she does not remember there being any obvious injuries to C1. PCA-I stated that after a fall, she was supposed to write an incident report and inform the nurse about the fall. PCA-I states she does not remember the details of the call to the nurse or if C1 was in pain after the fall. During an interview on September 21, 2017 at 12:00 p.m., family member (F)-H stated C1 had sustained multiple hip fractures at the facility and that they were never told that C1 needed a different level of care. F-H states that he was only notified about hospice two hours prior to C1 passing away. During an interview on August 14, 2017 at 12:38 p.m. with the driver (D)-E of the hospital discharge van service, D-E states that C1 was discharged from the hospital by the hospital nurse with thick sputum on her chin. The client was not responsive upon departure from the hospital or during the whole ride to the facility. During an interview on September 12, 2017 at 3:45 p.m., C1's primary medical doctor (MD)-D stated that the hip fracture was likely a contributing factor in the client's death.	0 325		

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0 325	Continued From page 7 During observation and interview in the memory care unit on August 10, 2017 from 10:00 a.m. to 6:30 p.m. with PCA-A, PCA-J, PCA-K, and PCA-L there was no effective way that staff could call for help in all areas of the unit. Multiple staff stated the way they call for assistance is to pull the emergency cord in the bathroom or press the client's pendant if they have one and then turn it off, and then repeat until staff realize and come to the room to assist. Staff state emergency cords are only in the bathroom, so they have to walk into a bathrooms to call for help if the client does not have a pendant, as not all client's have pendants. Staff were unable to show where the client's level of assistance was noted in their service plan. Staff stated that they know what the clients' need by word of mouth. Staff training records were reviewed, the fall prevention module was reviewed and indicated no procedure for what to do when a client in the facility falls. The fall prevention module indicated fall risk assessments were to be done on client's and with any change in condition, but no fall risk assessments were found in the chart for C1. There was no education present in the employee's record related to fall procedures or use of the personal alarm system. Although requested, the facility did not provide a policy or protocol related to falls, non-hospice death, CPR, assessments, or service plans that were in effect prior to the date of the onsite investigation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20207	A. BUILDING: _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT	200 22ND AVENUE NORTHEAST WASECA, MN 56093

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0 860	Continued From page 8	0 860		
0 860 SS=F	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on, document review and interview, the licensee failed to conduct initial assessments, 14 day assessments, and assessments after a change in condition for four of four clients reviewed, (C1), (C2), (C3), and (C4).	0 860		

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0 860	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: C1's record was reviewed. C1 had a diagnosis of Parkinson's disease, osteoporosis, and dementia, and received comprehensive home care services including assistance with personal care, bathing, and medication management according to service plan dated April 16, 2016. The client was residing in the memory care unit, and the actual specific services were obtained off of the resident profile and the service recap summary. C1 was admitted on June 19, 2015 and had an initial assessment dated June 14, 2015, no 14 day assessment was present. Initial assessment stated that client was independent with toileting and mobility, no 90 day assessment indicated any change in the assessment of the client or service plan, and on review of the chart client was no longer independent with any cares. C1 returned from the hospital on March 17, 2017 and July 5, 2017 after suffering hip fractures with a significant change in function and required a lift to be used for transfers. No assessment was done on C1's return from the hospital. C2's record was reviewed. C2 was receiving comprehensive home care services including assistance with toileting, bathing, and medication management. The service plan for C2 was dated	0 860		

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0 860	Continued From page 10 June 10, 2016, but had no services listed. The client was residing in the memory care unit, and the services were obtained off of the resident profile. The client was admitted to the facility on June 9, 2008. There was no initial or 14 day assessment present in the record. C3's record was reviewed. C3 was receiving comprehensive home care services including, assistance with toileting, dressing, and bathing. The service plan for C3 was signed and dated July 18, 2017, but had no services listed. The client was residing in the memory care unit, and the services were obtained off of the resident profile. C3 had an initial assessment dated July 11, 2017, but no 14 day assessment was present. C4's record was reviewed. C4 was receiving comprehensive home care services including assistance with bathing and medication administrations according to service plan signed and dated May 3, 2016. C4 was admitted to the facility on May 2, 2016, however C4 had an initial assessment dated March 11, 2016. No 14 day assessment was present, and the next 90 day assessment present is dated July 7, 2016. Director of nursing (DON)-A was interviewed on August 10, 2017 at 4:00 p.m. and said that they do not have an assessment policy, but she said according to state requirements, a significant change would trigger an assessment. DON-A states this was not done for C1. DON-A stated that there was not always the time to get out the paper to do the assessments. Registered nurse (RN)-B was interviewed on August 14, 2017 at 2:10 p.m. and said that she was not trained yet to do assessments.	0 860		

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0 860	Continued From page 11 Although requested, the facility did not provide a policy related to client assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 860		
0 870 SS=F	144A.4791, Subd. 9(f) Contents of Service Plan (f) The service plan must include: (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences; (2) the identification of the staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring reviews or assessments of the client; (4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and (5) a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) information and a method for a client or client's representative to contact the home care provider; (iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the	0 870		

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0 870	Continued From page 12 client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure the contents of the service plans for four of four clients reviewed, (C1), (C2), (C3), (C4), when the service plans did not contain the necessary components. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion of all of the clients). Findings include: C1's record was reviewed. C1 had a diagnosis of Parkinson's disease, osteoporosis, and dementia and received comprehensive home care services including assistance with personal care, bathing, and medication management according to service plan dated April 16, 2016. The client was residing in the memory care unit, and the actual specific services were obtained off of the resident profile and the service recap summary. Multiple assessments indicated that there was no change	0 870		

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0 870	Continued From page 13 needed in the service plan, however the client went from being independent with cares to needing total assitance with cares. The service plan stated the client was receiving "personal cares" daily, but did not give a description of the services that were being offered. According to the resident profile and the service recap summary, C1 was receiving many services not listed on the service plan. C2's record was reviewed. C2 was receiving comprehensive home care services including assistance with toileting, bathing, and medication management. The service plan for C2 was dated June 10, 2016, but had no services listed. The client was residing in the memory care unit, and the services were obtained off of the resident profile. The service plan did not give a description of the services, fees for services, or the frequency of each service. C3's record was reviewed. C3 was receiving comprehensive home care services including, assistance with toileting, dressing, and bathing. The service plan for C3 was signed and dated July 18, 2017, but had no services listed. The client was residing in the memory care unit, and the services were obtained off of the resident profile. The service plan did not give a description of the services, fees for services, or the frequency of each service. C4's record was reviewed. C4 was receiving comprehensive home care services including assistance with personal care, bathing, and medication administration according to service plan signed and dated May 3, 2016. The resident profile listed that the client was receiving assitance with toileting, repositioning, dressing, and medication administration. The service plan	0 870		

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0 870	Continued From page 14 stated the client was receiving "personal cares" daily, but did not give a description of the services that were being offered. According to the resident profile, C4 was receiving many services not listed on the service plan. Multiple documents titled 90 day supervisory visit notes were reviewed for C1, C2, C3, and C4 and they indicated the service plan did not need to be updated and the client's services were appropriate to the client's needs. Director of nursing (DON)-A was interviewed on August 10, 2017 at 4:00 p.m and said additional services are added into residex, and not on the service plan. Multiple direct care staff were interviewed on August 10, 2017 at 11:15 a.m. and on August 10, 2017 at 5:10 p.m. and stated that staff know what services and what level of assistance clients are by word of mouth and verbal communication. Multiple staff were unable to show a written service plan for the clients. Although requested. the facility did not provide a policy related to service plans. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 870		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3010 0001 4648 6163

December 26, 2017

Mr. Erik Worke, Administrator
Colony Court
200 22nd Avenue Northeast
Waseca, MN 56093

RE: Complaint Number HL20207003 and HL20207004

Dear Mr. Worke :

A complaint investigation (#HL20207003 and HL20207004) of the Home Care Provider named above was completed on October 5, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

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

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

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

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

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

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