DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Edgewood Hermantown Senior Living

Facility Address:
4195 Westberg Road

Facility City:
Hermantown

State:	ZIP:	County:
Minnesota	55811	Saint Louis

Report Number:
HL20852032

Time of Visit:
10:30 a.m. to 3:15 p.m.
8:30 a.m. to 1:15 p.m.

Investigator's Name and Title:
Rhylee Gilb, RN, Special Investigator
Amy Hyers, RN, Special Investigator

Date of Visit:
April 19 and 20, 2017

Date Concluded:
December 29, 2017

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the home care provider failed to provide supervision resulting in the client falling and was wedged between a table and unknown object. The client passed away due to a subdural hematoma.

☒ 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 home care provider failed to assess the client when the client had a bowel infection, which may have contributed to the client's fall. In addition, the primary cause of the client's death was due to the bowel infection, clostridium difficile (C-Diff), which was not identified and treated.

The client received services from a provider licensed as a comprehensive home care provider. The client's service plan included assistance with all activities of daily living, medication administration, bowel and bladder monitoring, and a secured unit with safety checks every 30 minutes. Staff assisted the client with toileting every two hours and the client utilized a bedside commode.

The client started on an antibiotic for pneumonia for ten days. Two weeks later, an update to the client's physician indicated s/he had a ten pound weight loss over the past month. A nutritional plan was started which included a daily nutritional supplement and weekly weights. In addition, the client's diet was downgraded from regular diet to ground food due to swallowing difficulties.

Approximately four weeks after starting the antibiotic, the client experienced diarrhea. The licensed practical nurse (LPN) listened to the client's bowel sounds, but did not complete any other monitoring or interventions. Two months later, staff reported the client had had diarrhea and emesis for two weeks. The director of nursing (DON) documented s/he updated the client's physician. However, no assessment of the client was completed and no monitoring or interventions were initiated.

The registered nurse (RN) completed the client's routine annual assessment five days prior to the client's death. Expressive aphasia (partial loss of speech) was the only change noted; the assessment did not address the symptoms of diarrhea that was documented two weeks prior. Two days after the annual assessment, the client continued to not feel well and experienced poor appetite and loose stools. The RN updated the client's physician and monitored the client's symptoms. Three days later, the client experienced a fall from his/her bed and was sent to the hospital. The client died the same day.

The client's death record indicated the primary cause of death was septic clostridium difficile diarrhea.

The client's bowel records and service logs were requested, however the DON stated client records were in the process of being relocated and some records were missing, lost, or accidentally destroyed. The DON stated there was a C-Diff outbreak in the memory care unit where the client resided, however the facility did not know the client had C-Diff until after s/he had passed away. The outbreak affected approximately five known clients. The LPN stated s/he had changed the client's incontinent product once or twice, but had not noticed anything suspicious. S/he stated it was determined after the client passed away his/her roommate also had C-Diff.

The client's physician stated the clients susceptibility to C-Diff was due to the exposure of antibiotics and C-Diff can predispose people to falls. The only update the physician received from the home care provider staff was three days prior to the client's death with complaints of him/her not feeling well with emesis and loose stools. The physician stated that if the client was treated for the illness earlier, s/he may have had a different outcome.

The client's family member stated the client told him/her about having loose stools approximately a week prior to his/her death. The family member thought it was from something the client ate. The family member was concerned about the home care provider's lack of infection control after the client had died. The family member stated s/he called the nurse to update the client was positive for C-Diff. However, the home care provider failed to clean and sanitize the client's room. Another client had wandered into the room and laid in the client's bed. Meanwhile, the client's roommate also contracted C-Diff. The family member stated staff were not using gloves or gowns.

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 client had multiple occasions of loose stools, with no assessment or intervention. Unlicensed staff utilized client concern forms to communicate changes to the nurses, however the client's concern records were missing. The client's bowel records were missing, which would have indicated how many loose stools.

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.

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] Care Guide
- [x] Medication Administration Records
- [x] Weight Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☒ Service Plan

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Personnel Records/Background Check, etc.

☒ 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: client is deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews:attempted

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

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:

☒ Call Light
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Meals
☒ Facility Tour
☒ 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

Saint Louis County Medical Examiners

Hermantown Police Department

Saint Louis County Attorney

Hermantown City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3010 0001 4648 6156

December 26, 2017

Ms. Traci Jaszczak, Administrator
Edgewood Vista Hermantown
4195 Westberg Road
Hermantown, MN 55811

RE: Complaint Number HL20852031 and HL20852032

Dear Ms. Jaszczak:

A complaint investigation (#HL20852031 and HL20852032) of the Home Care Provider named above was completed on September 11, 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
Saint Louis County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20852	A. BUILDING: _____ B. WING _____	C 09/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VISTA HERMANTOWN	4195 WESTBERG ROAD HERMANTOWN, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, 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 April 19 and 20, 2017, a complaint investigation was initiated to investigate complaints #HL20852031 & HL20852032. At the time of the survey, there were 203 clients that were receiving services under the comprehensive license. The following correction orders are issued. 144A.44 Subd. 1 (14) is issued related to HL20852032 144A.4791 Subd. 8 is issued related to HL20852032 144A.4791 Subd. 9 (a-e) is issued related to HL20852031 144A.4794 Subd. 3 is issued related to both HL20852031 & HL20852032	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who	0 325		

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0 325	Continued From page 1 receives home care services has these rights: (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 interview and document review the licensee failed to provide freedom from maltreatment (neglect) for one of five clients (C2) reviewed when the licensee failed to assess a significant change in condition. The client had persistent diarrhea and the client died from a bowel infection, clostridium difficile (C-Diff). This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The Mayo Clinic website indicates C-Diff is common in older adults after antibiotic use. Symptoms of C-Diff typically occur within five to ten days after starting an antibiotic, but may occur after the first day or up to two months later. Some symptoms include three or more watery stools a day (lasting more than two days), nausea, loss of appetite, and dehydration. C2's medical record was reviewed. C2's service plan, dated August 25, 2016, indicated C2 required assistance with assistance with all activities of daily living, medication assistance,	0 325		

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0 325	Continued From page 2 bowel and bladder monitoring, and a secured unit with safety checks every 30 minutes. C2's 90 day registered nurse (RN) assessment date August 20, 2016, indicated no health changes or service plan changes. C2 continued to require assistance with toileting every two hours. A nurse note dated September 16, 2016, indicated C2 started on Augmentin (antibiotic) for pneumonia for ten days. A provider communication note dated September 30, 2016 indicated C2's physician was updated regarding a ten pound weight loss in the past month. The licensee nurse indicated nutritional protocol (including starting a nutritional supplement daily) was started and weekly weights. In addition, a downgrade of diet from regular to mechanical soft was requested. C2's physician agreed with the plan. A nurse note dated October 11, 2016, indicated licensed practical nurse (LPN)-C listened to C2's bowel sounds after reports from unlicensed personnel (ULP) C2 had diarrhea. LPN-C indicated C2's bowel sounds were active, however no interventions were documented. On December 6, 2016, director of nursing (DON)-A indicated ULP staff reported C2 had diarrhea and emesis for two weeks. DON-A documented C2's physician was updated. There were no further notes about C2's diarrhea or interventions. C2's annual RN assessment dated December 21, 2016, indicated C2 refused cares, but still required assistance with dressing, grooming, bathing, and toileting every two hours. Expressive aphasia (partial loss of speech) was noted and	0 325		

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0 325	Continued From page 3 C2 required oxygen for shortness of breath. The assessment lacked any indication of an acute illness or symptoms of diarrhea. On December 23, 2016, a nurse note indicated C2 was not feeling well with poor appetite and loose stools. On December 26, 2016, C2 experienced a fall from bed and was sent to the hospital. C2's death record indicated C2 died on December 26, 2016. The cause of death was septic clostridium difficile diarrhea. C2's bowel record and service log were requested, but were not provided. On April 20, 2017, at 9:00 a.m. DON-A stated there was a C-Diff outbreak in the building and staff isolated approximately five known clients. It was not known C2 had C-Diff until after she was hospitalized on December 26, 2016. DON-A stated she could not recall much about C2's loose stools. Registered nurse (RN)-B, who was assigned to the unit, was a new employee at the time. DON-A stated she did not complete an RN assessment of C2. During an interview on September 5, 2017, at 4:55 p.m., with C2's physician, the physician stated C2's susceptibility to C-Diff was due to the exposure of antibiotics, and C-Diff can predispose people to falls. The licensee updated him on December 23, 2016 regarding C2 not feeling well for a couple days with symptoms of nausea, emesis, and diarrhea. There were no other updates from the licensee regarding diarrhea or a C-Diff outbreak in the facility; the physician did not have any record of having been contacted on December 6, 2016, as documented	0 325		

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0 325	Continued From page 4 by the facility. The physician stated that if C2 had treated for the illness, she may have had a different outcome. During an interview on September 6, 2017, at 1:55 p.m., LPN-C stated C2 had experienced swallowing difficulties and emesis. C2 was seen by her physician for the concern and decided not to pursue any interventions. About a month prior to C2's death, she heard a comment from ULP staff regarding C2 having diarrhea, but then heard it was resolved. LPN-C stated she changed C2's incontinent product once or twice but did not observe anything suspicious. After C2's death, it was discovered C2's roommate also had C-Diff, in addition to the other clients affected by the outbreak. On September 7, 2017 at 9:00 a.m., ULP-E stated C2's roommate had C-Diff then C2 started to get sick with loose, slimy diarrhea. She thought C2 had one or two episodes prior to her hospitalization. She did not communicate the loose stools herself, but believed both RN-B and LPN-C were aware. During an interview on September 8, 2017, at 9:00 a.m., ULP-E stated C2 had started getting sick with loose, slimy stools, but could not recall when it started. C2 had decreased engery, did not leave her bed much, and used a commode next her bed. ULP-E believed RN-B and LPN-C were aware, but had updated them on C2's status herself. The licensee policy titled "Assessments" dated January 2017 indicated a significant change in condition is any deviation from the client's clinical baseline. Vitals are obtained, documented in the progress notes along with clinical symptoms. In	0 325		

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0 325	Continued From page 5 addition, a standardized nursing assessment is completed. Findings are reported to the physician as necessary. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		
0 860 SS=J	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.	0 860		

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0 860	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to complete a comprehensive assessment for one of five clients (C2) reviewed, when C2 had a change in condition. C2 experienced symptoms of a bowel infection, which resulted in death. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C2's medical record was reviewed. C2's service plan, dated August 25, 2016, indicated C2 required assistance with assistance with all activities of daily living, medication assistance, bowel and bladder monitoring, and a secured unit with safety checks every 30 minutes. C2's 90 day registered nurse (RN) assessment date August 20, 2016, indicated no health changes or service plan changes. C2 continued to require assistance with toileting every two hours. A nurse note dated September 16, 2016, indicated C2 started on Augmentin (antibiotic) for pneumonia for ten days. A provider communication note dated September 30, 2016 indicated C2's physician was updated regarding a ten pound weight loss in the past	0 860		

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0 860	Continued From page 7 month. The licensee nurse indicated nutritional protocol (including starting a nutritional supplement daily) was started and weekly weights. In addition, a downgrade of diet from regular to mechanical soft was requested. C2's physician agreed with the plan. A nurse note dated October 11, 2016, indicated licensed practical nurse (LPN)-C listened to C2's bowel sounds after reports from unlicensed personnel (ULP) C2 had diarrhea. LPN-C indicated C2's bowel sounds were active, however no interventions were documented. On December 6, 2016, director of nursing (DON)-A indicated ULP staff reported C2 had diarrhea and emesis for two weeks. DON-A documented C2's physician was updated. There were no further notes about C2's diarrhea or interventions. C2's annual RN assessment dated December 21, 2016, indicated C2 refused cares, but still required assistance with dressing, grooming, bathing, and toileting every two hours. Expressive aphasia (partial loss of speech) was noted and C2 required oxygen for shortness of breath. The assessment lacked any indication of an acute illness or symptoms of diarrhea. On December 23, 2016, a nurse note indicated C2 was not feeling well with poor appetite and loose stools. On December 26, 2016, C2 experienced a fall from bed and was sent to the hospital. C2's death record indicated C2 died on December 26, 2016. The cause of death was septic clostridium difficile diarrhea. C2's bowel record and service log were requested, but were not provided.	0 860		

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	H20852	A. BUILDING: _____ B. WING _____	C 09/11/2017

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0 860	Continued From page 8 On April 20, 2017, at 9:00 a.m. DON-A stated there was a C-Diff outbreak in the building and staff isolated approximately five known clients. It was not known C2 had C-Diff until after she was hospitalized on December 26, 2016. DON-A stated she could not recall much about C2's loose stools. Registered nurse (RN)-B, who was assigned to the unit, was a new employee at the time. DON-A stated she did not complete an RN assessment of C2. During an interview on September 5, 2017, at 4:55 p.m., with C2's physician, the physician stated C2's susceptibility to C-Diff was due to the exposure of antibiotics, and C-Diff can predispose people to falls. The licensee updated him on December 23, 2016 regarding C2 not feeling well for a couple days with symptoms of nausea, emesis, and diarrhea. There were no other updates from the licensee regarding diarrhea or a C-Diff outbreak in the facility; the physician did not have any record of having been contacted on December 6, 2016, as documented by the facility. The physician stated that if C2 had treated for the illness, she may have had a different outcome. During an interview on September 6, 2017, at 1:55 p.m., LPN-C stated C2 had experienced swallowing difficulties and emesis. C2 was seen by her physician for the concern and decided not to pursue any interventions. About a month prior to C2's death, she heard a comment from ULP staff regarding C2 having diarrhea, but then heard it was resolved. LPN-C stated she changed C2's incontinent product once or twice but did not observe anything suspicious. After C2's death, it was discovered C2's roommate also had C-Diff, in addition to the other clients affected by the	0 860		

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0 860	Continued From page 9 outbreak. On September 7, 2017 at 9:00 a.m., ULP-E stated C2's roommate had C-Diff then C2 started to get sick with loose, slimy diarrhea. She thought C2 had one or two episodes prior to her hospitalization. She did not communicate the loose stools herself, but believed both RN-B and LPN-C were aware. During an interview on September 8, 2017, at 9:00 a.m., ULP-E stated C2 had started getting sick with loose, slimy stools, but could not recall when it started. C2 had decreased engery, did not leave her bed much, and used a commode next her bed. ULP-E believed RN-B and LPN-C were aware, but had updated them on C2's status herself. The licensee policy titled "Assessments" dated January 2017 indicated a significant change in condition is any deviation from the client's clinical baseline. Vitals are obtained, documented in the progress notes along with clinical symptoms. In addition, a standardized nursing assessment is completed. Findings are reported to the physician as necessary. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 860		
0 865 SS=D	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care	0 865		

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0 865	Continued From page 10 provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to revise a client's service plan after a return from the hospital and required an increased need for assistance with additional services for one of five clients (C1) reviewed.	0 865		

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0 865	Continued From page 11 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1's service plan dated April 19, 2016, indicated C1 required assistance with medication administration, coumadin management, bathing weekly, oxygen therapy, and daily blood pressure monitoring. C1's 90 day RN assessment dated July 28, 2016, indicated C1 continued to dress and groom herself independently. C1 utilized oxygen as needed during the night. No changes to her service plan were indicated. C1's nurse notes were reviewed. On August 4, 2016, C1 experienced a fall with left shoulder pain and was sent to the hospital. August 5, 2016, C1 was admitted to the hospital with a diagnoses of a left clavicle fracture. August 8, 2016, C1 was discharged to a skilled nursing facility for rehabilitation. A nurse note dated September 7, 2016, indicated C1 returned to the licensee and required assistance with activities of daily living, ambulation, and transfers until cleared by therapy to perform tasks independently. In addition, C1 required oxygen continuously. A readmission RN assessment date September	0 865		

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0 865	Continued From page 12 7, 2016, indicated C1 required assistance of one person for dressing, grooming, bathing, toileting, ambulation, and transfers. C1 continued to use a walker and a wheelchair. C1 had physical therapy and occupational therapy outpatient services. C1's record lacked an updated service plan for these increased services. During an interview on September 6, 2017 at 1:35 p.m., C1's family member stated staff did not discuss new services C1 required and the family did not receive a new service plan. Normally, the licensee would increase services when it was needed and it was reflected on the bill. On September 6, 2017 at 2:30 p.m., RN-B stated she completed C1's readmission RN assessment, but could not recall if her service plan was changed or updated. Unlicensed staff were communicated changes in C1's need by reviewing the updated care plan and signing off on it. The licensee policy titled "Documentation" dated January 2017, indicated under the section "Resident Service Plan/Care Plan" the service plan should be complete, accurate and reflect services as planned. The licensee policy titled "Service Planning/ Care Planning/ Coordination of Care" dated July 2017, indicated the service plan will be reviewed for need of changes at least annually and with changes in condition. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 865		

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01080	Continued From page 13	01080		
01080 SS=E	144A.4794, Subd. 3 Contents of Client Record Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights;	01080		

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01080	Continued From page 14 (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the licensee failed to maintain bowel records and concern notes in the client record for one of five clients (C2) reviewed. In addition, record of services were not maintained for two of five clients (C1, C2). 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 pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C2's medical record was reviewed. C2's service plan dated August 25, 2016, indicated C2 required assistance with assistance with all activities of daily living, medication assistance,	01080		

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01080	Continued From page 15 bowel and bladder monitoring and secured unit with safety checks every 30 minutes. C2's nurse notes were reviewed. On September 16, 2016, C2 started on Augmentin (antibiotic) for pneumonia. On October 11, 2016, licensed practical nurse (LPN)-C listened to C2's bowel sounds after reports from unlicensed personnel (ULP) C2 had diarrhea. LPN-C indicated C2's bowel sounds were active, however did not document any interventions. On December 6, 2016, director of nursing (DON)-A indicated ULP staff reported C2 had diarrhea and emesis for two weeks. DON-A documented C2's physician was updated. There were no further notes about C2's diarrhea or any interventions. On December 23, 2016, a nurse note indicated C2 was not feeling well with poor appetite and loose stools. On December 26, 2016, C2 experienced a fall from bed and sent to the hospital. C2's death record indicated C2 died on December 26, 2016. The cause of death was septic clostridium difficile diarrhea (C-Diff), a bowel infection. C2's bowel records, concern notes, and services provided records were requested, but none were provided. C1's medical record was reviewed. C1's service plan dated April 19, 2016, indicated C1 required assistance with medication administration, coumadin management, bathing weekly, oxygen therapy, and daily blood pressure monitoring. C1's 90 day RN assessment dated July 28, 2016, indicated C1 continued to dressing and groom herself independently. C1 utilized oxygen as	01080		

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01080	Continued From page 16 needed during the night. No changes to her service plan were indicated. C1's nurse notes were reviewed. On August 4, 2016, C1 experienced a fall with left shoulder pain and was sent to the hospital. August 5, 2016, C1 was admitted to the hospital with a diagnoses of a left clavicle fracture. On August 8, 2016, C1 was discharged to a skilled nursing facility for rehabilitation. A nurse note dated September 7, 2016, indicated C1 returned to the licensee and required assistance with activities of daily living, ambulation and transfers until cleared by therapy to perform tasks independently. In addition, C1 required oxygen continuously. A readmission RN assessment date September 7, 2016, indicated C1 required assistance of one person for dressing, grooming, bathing, toileting, ambulation, and transfers. C1 continued to use a walker and a wheelchair. C1 had physical therapy and occupational therapy outpatient services. C1's services provided records was requested, none were provided. During an on-site visit on April 19, 2017 , client records were observed in multiple piled stacks sitting on desks in a room. During an interview with DON-A on April 20. 2017, at 9:00 a.m., DON-A stated the client records were unorganized and in the process of relocating offices. Bowel records were completed on memory care clients and staff filled out client concerns forms to communicate with nurses on any concerns with a client. C2's bowel records and concern forms could not be found, and	01080		

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01080	Continued From page 17 DON-A stated another nurse may have shredded them by accident. The licensee policy titled "Documentation" dated January 2017, indicated the licensee is to maintain complete, ongoing and organized client records to convey health history, status and communication among practitioners. Unlicensed personnel are to utilize a "Resident Concern Log" to communicate and document any changes regarding the client. The client records include elimination of bowel and bladder and progress notes that reflect care provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01080		