MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Hugo Gracewood LLC		**Report Number:** HL23369006	**Date of Visit:** June 14 and 15, 2016
Facility Address: 5607 North 150th Street		**Time of Visit:** 8:00 a.m.- 4:45 p.m. 8:30 a.m.- 11:00 a.m.	**Date Concluded:** August 24, 2016
Facility City: Hugo		**Investigator's Name and Title:** Rhylee Gilb, RN Special Investigator	
State: Minnesota	**ZIP:** 55038	**County:** Washington	

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged clients are being abused when the alleged perpetrators treated clients in a disparaging and humiliating manner, taking photos and video of clients with props indicating illicit behavior.

☒ 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, two clients were abused when staff took disparaging and humiliating videos of clients and shared them via text and social media. Four alleged perpetrators were identified. AP #1 took and shared videos, AP #2 witnessed video staging, received and shared video, AP #3 was present when video was recorded and received video, and AP #4 sent video. Two videos were reviewed in the investigation and two more videos were discussed in interviews.

Client #1 received services due to diagnoses that included dementia, and required assistance for activities of daily living (ADLs). Client #1 was unable to report maltreatment related to memory impairment.

Client #2 received services due to diagnoses that included Alzheimer's disease, and required assistance with all ADLs. Client #2 was unable to report maltreatment due to severe memory impairment.

Video #1 was obtained from a staff cell phone belonging to AP #3. Video #1 portrayed client #2 dressed in a white tee shirt, sitting in a wheelchair at a table. A white powdered substance was spread under the client's nose and the same white powdered substance was on the table placed in three straight lines. Client #2 was experiencing arm tremors. The song "Cocaine" by Eric Clapton was playing in the background.

Video #2 was obtained from a staff member who received it from AP #4 via social media. Video #2 was dark and difficult to see. However, client #1 was heard yelling in distress.

During an interview with a staff member, s/he stated AP #1 showed him/her two videos (video #1 and video #3) of client #2, on AP #1's personal cellphone. The description of the first video was consistent with video #1: client #2 was sitting in a wheelchair at a table, and had powdered sugar on the table in lines and under his/her nose. The staff member stated it made it look like the client was using cocaine. The staff member stated that video #3 portrayed client #2 holding an empty alcohol bottle while another unidentified staff member was pushing the client's wheelchair, with "rock music" playing in the background. The staff member stated AP #1 had said s/he found the empty alcohol bottle, brought it into the home care provider, and gave it to client #2 to hold.

During an interview with another staff member, s/he stated s/he had seen two different videos (video #2 and video #4) of client #1. The staff member stated AP #4 had sent him/her a message via social media with video #2 stating that client #1 is mad and will not let anyone help him/her. The staff member stated the client #1 was sitting on the toilet, yelling at staff in video #2. The staff member stated video #4 was viewed on AP #1's personal cell phone. S/he stated video #4 showed client #1 on the toilet and AP #3 in the bathroom with client #1 while AP #1 recorded. The staff member stated client #1 said "you guys are going to go to hell" and either AP#1 or AP#3 said "we'll see you there."

An interview with AP #1 was attempted. A subpoena was sent to AP #1. AP #1 failed to respond or attend the scheduled interview.

An interview with AP #2 was completed. AP #2 stated s/he worked with AP #1 on the evening shift when video #1 of client #2 was taken. AP #2 stated that after s/he finished his/her final rounds, s/he saw client #2 sitting at the table in the common area. S/he stated the powdered sugar was on the table and looked like cocaine. AP #2 stated that AP #1 sent him/her video #1 via text message, and then s/he sent it to AP #3. AP #2 stated s/he knew it was not acceptable to take videos of clients, but did not report to management because s/he did not want to get involved.

During an interview with AP #3, s/he stated s/he received video #1 of client #2 in April 2016 from AP #2 via text message. AP #3 stated AP #1 and AP #2 were working the night when video #1 was taken. AP #3 stated video #1 was of client #2 with powdered sugar on his/her nose and lines of powdered sugar to look like cocaine. AP #3 stated s/he has seen a video of client #2 with a bottle of vodka that AP #1 had brought into the home care provider and gave to client #2. AP #3 stated s/he knew taking a video of a client was wrong, but acknowledged s/he did not report the incident. AP #3 stated s/he has never seen a picture or video of client #1 sitting on the toilet and has never sent any pictures of a client sitting on the toilet.

An interview with AP #4 was completed. AP #4 stated s/he never sent a video of a client via social media and does not know why someone would say s/he had.

During an interview with the House Manager, s/he stated s/he was aware of inappropriate picture taking occurring on the evening shift while s/he was a lead caregiver. S/he stated another staff member reported AP #1 sent a picture of one of the clients through text message. The Housing Manager stated s/he confronted AP #1 who said s/he had taken pictures of the clients. The Housing Manager stated s/he reported it to the housing manager at the time, and the Housing Manager instructed him/her to educate

the staff on the cellphone policy. S/he looked for an internal investigation or vulnerable adult report and neither was found to have been completed by the home care provider.

During an interview with the registered nurse, s/he stated s/he was unaware of staff taking pictures or videos of clients.

During an interview with client #1, s/he was confused and upset. Client #1 could not recall if any photographs or videos had been taken of him/her.

During an interview with client #1's family member, the family member stated s/he has not heard client #1 complain about staff nor seen any staff take pictures or video of client #1. However, the family member stated s/he only visits during the day.

An interview with client #2 was attempted, however client #2 was asleep and was unable to be aroused for the interview.

During an interview with client #2's family member, the family member stated client #2 is unable to recall events. The family member stated s/he was not aware of any videos or pictures being taken by the staff.

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:

Video evidence exists of disparaging videos of clients. Multiple staff were involved. The facility was aware, but failed to investigate.

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:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Medication Administration Records
- [x] Assessments
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

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

Number of additional resident(s) reviewed: five

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, 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: ten

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ◉ No ○ N/A Specify: AP#1 refused to interview

Attempts to contact:

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

If unable to contact was subpoena issued: ◉ Yes, date subpoena was issued 6/17/2016 ○ No

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ Personal Care
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy 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: photographs and video evidence received from AP#

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Washington County Attorney

Hugo City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23369	A. BUILDING: _____ B. WING _____	C 07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGO GW LLC	5607 NORTH 150TH STREET HUGO, MN 55038

(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 6/14/2016, a complaint investigation was initiated to investigate complaint #HL23369009 . At the time of the survey, there were 22 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.	
0 320 SS=F	144A.44, Subd. 1(13) Treated With Respect Subdivision 1. Statement of rights. A person who receives home care services has these rights: (13) the right to be treated with courtesy and respect, and to have the client's property treated with respect;	0 320		

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0 320	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview, document review, and review of photographic images the licensee failed to ensure staff treated clients with respect for five of six clients (C3, C4, C5, C2 and C6) reviewed when staff took photographs of clients. 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 potential to affect a large portion or all of the clients). The findings include: C3's medical record was reviewed. C3 was admitted with diagnoses that included dementia. The service plan dated 5/11/16 indicated C3 required assistance with dressing, grooming and medications and cues for all other activities of daily living (ADL's). The vulnerability assessment dated 8/6/15 indicated C3 was vulnerable for abuse due to being a poor historian and would not be capable of accurately reporting abuse. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. One photograph was taken by ULP-J on her personal cell phone of C3. The photograph of C3, dressed in a grey shirt, with ULP-J to her left and ULP-I standing behind her. C3 and ULP-I both had a lollipop in their mouths and ULP-J was holding a lollipop next to her mouth. C4's medical record was reviewed. C4 was	0 320		

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0 320	Continued From page 2 admitted with diagnoses that included Crohn's disease. The service plan dated 10/14/15 indicated C4 required assistance with all ADL's including medications. The vulnerability assessment dated 10/14/15 indicated C4 had identified areas of vulnerability due to being hard of hearing. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. One photograph was taken by ULP-J on her personal cell phone of C4. The photograph displayed C4 wearing a striped, turtle neck sweater with ULP-J to her right and ULP-I to her left. They were all smiling in the photo. C5 's medical record was reviewed. C5 was admitted with diagnoses that included dementia. The service plan dated 5/10/16 indicated C5 required assistance with all ADL's including medications. The vulnerability assessment dated 4/6/16 indicated C4 was vulnerable for abuse due to dementia and inability to report abuse/neglect. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during an on-site investigation. Two photos were taken by ULP-J on her personal cell phone of C5. The photographs of C5 were of her alone, sitting in a wheelchair, holding a doll. C5 was wearing a white t-shirt with black stripes and grey pants. C2's medical record was reviewed. C2 was admitted to the licensee with diagnoses that included Alzheimer's. The service plan dated 1/5/15 indicated C2 required assistance for all ADL's including medication administration. C2 ambulated independently. The vulnerability assessment dated 7/10/15 indicated C2 was vulnerable for abuse related to dementia and the	0 320		

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0 320	Continued From page 3 inability to recall events and report maltreatment. No photographic evidence was available. C6's medical record was reviewed. C6 was admitted to the licensee with diagnoses that included Lewy body dementia and Alzheimer's disease. The service plan dated 5/11/16 indicated C6 required assistance with all ADL's including medications. The vulnerability assessment dated 5/11/16 indicated C6 was vulnerable for abuse due to the inability to verbalize his needs. No photographic evidence was available. During an interview with the House Manager on 6/14/16, at 1:35 p.m. she stated there was inappropriate picture taking occurring on the evening shift while she was a lead caregiver. She stated a staff member reported that evening staff member sent a picture of one of the clients through text message. She stated she did confront ULP-H who did admit to taking pictures of the clients. The House Manager stated she did not ask to see the picture and told the staff to delete it. The House Manager stated she reported it to the housing manager at the time and the housing manager instructed her to educate the staff on the cell phone policy. An interview on 6/14/16, at 3:00 p.m. ULP-K she stated she received one picture of C2 from ULP-H. C2 was dressed in a grey sweatshirt with a hat on. ULP-K stated she received pictures of C2, C3 and C4 on snap chat (social media) from ULP-I and ULP-J. ULP-K was unsure of how many photos she had received or further descriptions. ULP-K stated she took one picture of C2 and herself. ULP-K stated C2 was dressed in normal clothes, but did not send it to anyone. Dates of pictures taken were unknown.	0 320		

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0 320	Continued From page 4 On 6/14/16, at 3:35 p.m. ULP-J stated she had taken pictures of C3, C4 and C5 for personal use. ULP-J stated the photograph for C3 was sent via text message to ULP-H in April 2016. ULP-J could not recall how many photos were taken or descriptions, but did provided images of C3, C4 and C5 she had on her cell phone. ULP-J stated she had seen ULP-H physically taking photographs of clients and ULP-H had sent her photos of C2, C4, C5 and C6 via text message and snap chat. ULP-J was unsure if the photos were sent anywhere else and thought this took place between December 2015 and January 2016. ULP-J stated she knew taking pictures of clients was breaking client privacy policy. She acknowledged she did not have consent to take pictures of clients. The licensee policy titled "Cell Phone Policy" dated 01/2013, states the use of personal cell phones while on duty is prohibited. Licensee staff may only use cell phones when they are on a fifteen minute break and outside of the building. The licensee form titled "Resident Photographic Release" states that photos taken by an employee will be used for internal postings only and for advertising/publication of the licensee. The licensee client admission packet includes the Home Care Bill of Rights provided to each client and their family. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 320		
0 325 SS=H	144A.44, Subd. 1(14) Free From Maltreatment	0 325		

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0 325	Continued From page 5 Subdivision 1. Statement of rights. A person who 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 on interview and video review the licensee failed to ensure clients were free from abuse when staff took videos that were disparaging, derogatory and humiliating for two of six clients (C2, C1) reviewed. 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 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 was admitted with diagnoses that included Alzheimer's. The service plan dated 1/5/15 indicated the client received assistance for all activities of daily living (ADL's) including medication administration. C2 ambulated independently. The vulnerability assessment dated 7/10/15 indicated C2 was vulnerable for abuse related to dementia and the inability to recall events and report maltreatment. Video evidence was collected and reviewed on 6/14/16 from ULP-J during the on-site	0 325		

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0 325	Continued From page 6 investigation. The video showed C2, sitting in a wheelchair at a table wearing a white tee shirt and glasses. C2 had a white powdered substance spread under his nose and the same white powdered substance was placed on the table in three separate straight lines. The video had the song "Cocaine" by Eric Clapton playing in the background and C2 was having arm tremors. C2's facial expression was flat and C2 saluted at the end of the video. During an interview with ULP-J on 6/14/16, at 3:35 p.m. she stated she received a video of C2 on 4/17/16 from ULP-I displaying powdered sugar on his nose and lines of powdered sugar to look like cocaine. ULP-J stated ULP-H and ULP-I were working the night the video was taken, but she was unsure who took the video and the date the video was taken. ULP-J stated she's also seen a video of C2 with a bottle of vodka that ULP-H had brought into the licensee and gave to C2. ULP-J stated she knew taking a video of C2 was wrong, but did not report because ULP-H was her friend and ULP-I was her brother. During an interview with with ULP-M on 6/21/16, at 3:10 p.m. she stated ULP-H showed her two videos of C2 on ULP-H's cell phone. ULP-M stated ULP-H took a video of C2 holding an empty alcohol bottle. An unidentified staff member was pushing C2 in his wheelchair and rock music was playing in the background. ULP-M stated ULP-H told her she found the empty alcohol bottle outside. ULP-M stated the second video of C2 was him sitting in a wheelchair at the table, had powdered sugar on the table in lines and under his nose. ULP-M stated it looked like C2 was doing cocaine. C1's medical record was reviewed. C1 was	0 325		

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0 325	Continued From page 7 admitted with diagnoses that included dementia. The service plan dated 5/10/16 indicated C1 required assistance for all ADL's including medication administration. The vulnerability assessment dated 3/23/16 indicated C1 was vulnerable for abuse related to dementia and making nonsensical speech. Video evidence was received and reviewed on 6/21/16, however the video was dark and unable to identify who was in the video. Audio was of a woman yelling. During an interview with with unlicensed personnel (ULP)-M on 6/21/16, at 3:10 p.m. she stated she watched a video on ULP-H's cell phone. She stated the video was of C1 on the toilet. ULP-M stated ULP-J was in the video and ULP-H recorded it. ULP-M stated C1 said "you guys are going to go to hell" and either ULP-H or ULP-J said "we'll see you there." ULP-M stated she received a video from ULP-L through a Facebook (social media) message. ULP-M stated that video was of C1 taken by ULP-L sitting on the toilet, yelling at the licensee staff. ULP-M stated ULP-L had sent her a message with the video stating, C1 is mad and won't let anyone help her with cares. The licensee form titled "Resident Photographic Release" states that photographs and video recordings taken by an employee will be used for internal postings only and for advertising/publication of the licensee. The licensee policy titled Cell Phone Policy dated 01/2013 states the use of personal cell phones while on duty is prohibited. Licensee staff may only use cell phones when they are on a fifteen minute break and outside of the building.	0 325		

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0 325	Continued From page 8 The licensee policy titled HIPAA and Minnesota Privacy Requirements dated 01/2014 states a notice of HIPAA will be provided to clients and a policy and procedure will be developed to comply with the law. Requested on 6/29/16 a more detailed HIPPA policy from the house manager, but none was provided. The licensee resident admission packet includes the Home Care Bill of Rights provided to each client and their family. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 815 SS=E	144A.479, Subd. 7 Employee Records Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 815		

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0 815	Continued From page 9 qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide a record of background checks completed on two of eight employees (ULP-K and ULP-M) reviewed. 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	0 815		

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0 815	Continued From page 10 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: ULP-K's personnel file was reviewed on 6/14/16. ULP-K was hired on 7/6/15. A consent to complete a background study was signed by ULP-K on 7/1/15. There was no record of a completed background study in the personnel file. ULP-M's personnel file reviewed on 6/14/16. ULP-M was hired on 4/5/16. There was no record of a completed background study in the personnel file. During an interview with the House Manager on 6/14/16, at 1:35 p.m. she stated she would contact the cooperate office for record of the background studies for ULP-K and ULP-M. The licensee policy titled Personnel Records dated 10/30/15 states each employee personnel record will include documentation of a completed criminal background study. The licensee policy titled Screening of Home Care Job Applicants dated 10/30/15 states upon conclusion of an applicant interview, the house manager will ask the applicant for a consent to complete a background check. Once the background check has been completed and an applicant is not disqualified, the house manager may extend an offer of employment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 815		

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01225	Continued From page 11	01225		
01225 SS=F	144A.4797, Subd. 3 Supervision of Staff - Comp Subd. 3. Supervision of staff providing delegated nursing or therapy home care tasks. (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client. (b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide direct supervision by a registered nurse of staff performing delegated tasks within 30 days of hire for seven of eight employees (ULP-G, ULP-H, ULP-I, ULP-J, ULP-K, ULP-L, ULP-M) reviewed.	01225		

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01225	Continued From page 12 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 potential to affect a large portion or all of the clients). The findings include: ULP-G's personnel file was reviewed. ULP-G was hired on 3/15/16. There was no record of a registered nurse (RN) supervisory visit completed in the personnel file nor stored electronically. ULP-H's personnel file was reviewed. ULP-H was hired on 7/20/15. There was no record of a RN supervisory visit completed in the personnel file nor stored electronically. ULP-I's personnel file was reviewed. ULP-I was hired on 8/7/15. There was no record of a RN supervisory visit completed in the personnel file nor stored electronically. ULP-J's personnel file was reviewed. ULP-J was hired on 9/24/15. There was no record of a RN supervisory visit completed in the personnel file nor stored electronically. ULP-K's personnel file was reviewed. ULP-K was hired on 7/6/15. There was no record of a RN supervisory visit completed in the personnel file nor stored electronically. ULP-L's personnel file was reviewed. ULP-L was hired on 4/25/16. There was no record of a RN supervisory visit completed in the personnel file nor stored electronically.	01225		

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01225	Continued From page 13 ULP-M's personnel file was reviewed. ULP-M was hired on 4/5/16. There was no record of a RN supervisory visit completed in the personnel file nor stored electronically. During an interview with the RN-A on 6/14/16, at 1:10 p.m. she stated no RN supervisory visits of a new employee have been completed within 30 days of hire. RN-A stated she did not know that was a requirement. The licensee policy titled Supervision of Licensed and Unlicensed Personnel dated 10/30/15 states direct supervision of unlicensed staff providing delegated nursing tasks will be competed within 30 days after an employee begins working for the licensee. An RN will directly supervise the initial direct supervision of unlicensed staff. The licensee policy titled Personnel Records dated 10/30/15 states that an employee's personnel file will included the results of the supervision observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01225		
02015 SS=I	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	02015		

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02015	Continued From page 14 individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or	02015		

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02015	Continued From page 15 facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, document review and review of video/photographic evidence the licensee failed to report suspected maltreatment when staff reported pictures and videos were taken of clients for six of six clients (C2, C1, C3, C4, C5 and C6) reviewed. 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 serious injury, impairment, or death); and, is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: The licensee policy titled Vulnerable Adult Reporting and Investigation Policy dated 1/27/16 states any staff person who witnesses or suspects any form of maltreatment must immediately report the incident to the registered nurse (RN) or house manager if RN is not available. If the incident appears to be suspected abuse, neglect or financial exploitation, the RN shall immediately (no more than 24 hours) report to Minnesota Adult Abuse Reporting Center.	02015		

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02015	Continued From page 16 C2's medical record was reviewed. C2 was admitted with diagnoses that included Alzheimer's. The service plan dated 1/5/15 indicated the client required assistance for all activities of daily living (ADL's) including medication administration. C2 ambulated independently. The vulnerability assessment dated 7/10/15 indicated C2 was vulnerable for abuse related to dementia and the inability to recall events and report maltreatment. Video evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. The video was of C2, sitting in a wheelchair at a table. C2 wore a white tee shirt and glasses. C2 had a white powdered substance spread under his nose and the same white powdered substance was placed on the table in three separate straight lines. The video had the song "Cocaine" by Eric Clapton playing in the background and C2 was having arm tremors. C2's facial expression was flat and C2 saluted at the end of the video. During an interview with ULP-K on 6/14/16, at 3:00 p.m. she stated she received a picture of C2 from ULP-H. C2 was dressed in a grey sweatshirt with a hat on. ULP-K stated she received pictures of on snap chat (social media) from ULP-I and ULP-J. ULP-K could not recall when she received the pictures. ULP-K stated she took a picture of C2 and herself. ULP-K stated C2 was dressed in normal clothes and she did not send it to anyone else. During an interview with ULP-J on 6/14/16, at 3:35 p.m. she stated ULP-H sent her pictures of C2 via text message and snap chat. ULP-J stated she thought this had occurred between	02015		

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02015	Continued From page 17 December 2015 and January 2016. ULP-J stated she received the video of C2 on 4/17/16 from ULP-I displaying powdered sugar on his nose and lines of powdered sugar to look like cocaine. ULP-J stated ULP-H and ULP-I were working the night the video was taken, but she was unsure who took the video. ULP-J stated she has also seen a video of C2 with a vodka bottle that ULP-H had brought into the licensee and gave to C2. ULP-J stated she knew taking a video of C2 was wrong, but did not report because ULP-H was her friend and ULP-I was her brother. During an interview with with ULP-M on 6/21/16, at 3:10 p.m. she stated ULP-H showed her two videos of C2 taken by ULP-H on ULP-H's cell phone. ULP-M stated the first video was of C2 holding an empty alcohol bottle. An unidentified staff member was pushing C2 in his wheelchair and rock music was playing in the background. ULP-M stated ULP-H told her she found the empty alcohol bottle outside. ULP-M stated the second video was of C2. C2 was sitting in a wheelchair at the table, had powdered sugar on the table in lines and under his nose. ULP-M stated it looked like C2 was doing cocaine. C1's medical record was reviewed. C1 was admitted with diagnoses that included dementia. The service plan dated 5/10/16 indicated C1 required assistance for all ADL's including medication administration. The vulnerability assessment dated 3/23/16 indicated C1 was vulnerable for abuse related to dementia and making nonsensical speech. During an interview with with unlicensed personnel (ULP)-M on 6/21/16, at 3:10 p.m. she stated she saw a video of C1 on the toilet on ULP-H's cell phone. ULP-M stated ULP-J was in	02015		

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02015	Continued From page 18 the video and ULP-H recorded it. ULP-M stated C1 said "you guys are going to go to hell" and either ULP-H or ULP-J said "we'll see you there." ULP-M stated she also received a video from ULP-L through a Facebook (social media) message. ULP-M stated the video was of C1 taken by ULP-L sitting on the toilet, yelling at the licensee staff. ULP-M stated ULP-L had sent her a message with the video stating, C1 is mad and will not let anyone help her with cares C3's medical record was reviewed. C3 was admitted with diagnoses that included dementia. The service plan dated 5/11/16 indicated C3 required assistance with dressing, grooming and medications and cues for all other ADL's. The vulnerability assessment dated 8/6/15 indicated C3 was vulnerable for abuse due to being a poor historian and would not be capable of accurately reporting abuse. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. One photograph was taken by ULP-J on her personal cell phone of C3. The photograph displayed C3, dressed in a grey shirt, with ULP-J to her left and ULP-I standing behind her. C3 and ULP-I both had a lollipop in their mouths and ULP-J was holding a lollipop next to her mouth. During an interview with ULP-J on 6/14/16, at 3:35 p.m. stated that she had taken pictures of C3 and thought pictures were taken between December 2015 and January 2016. C4's medical record was reviewed. C4 was admitted with diagnoses that included Crohn's disease. The service plan dated 10/14/15 indicated C4 required assistance with all ADL's including medications. The vulnerability assessment dated 10/14/15 indicated C4 had	02015		

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02015	Continued From page 19 identified areas of vulnerability due to being hard of hearing. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. One photograph was taken by ULP-J on her personal cell phone of C4. The photograph showed C4 wearing a stripped, turtle neck sweater with ULP-J to her right and ULP-I to her left. They were all smiling in the photo. During an interview with ULP-K on 6/14/16, at 3:00 p.m. stated she received pictures of C3 and C4 on snap chat from ULP-I and ULP-J but was unsure when. C5's medical record was reviewed. C5 was admitted with diagnoses that included dementia. The service plan dated 5/10/16 indicated C5 required assistance with all ADL's including medications. The vulnerability assessment dated 4/6/16 indicated C4 was vulnerable for abuse due to dementia and inability to report abuse/neglect. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. Two photos were taken by ULP-J on her personal cell phone of C5. The photographs of C5 portrayed C5 alone, sitting in a wheelchair and holding a doll. C5 was wearing a white t-shirt with black stripes and grey pants. During an interview with ULP-J on 6/14/16, at 3:35 p.m. stated ULP-H had sent her pictures of C4 and C5 via text message and snap chat. ULP-J stated that she had taken pictures of C4 and C5 and thought this had taken place between December 2015 and January 2016. C6's medical record was reviewed. C6 was	02015		

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02015	Continued From page 20 admitted with diagnoses that included Lewy body dementia and Alzheimer's disease. The service plan dated 5/11/16 indicated C6 required assistance with all ADL's including medications. The vulnerability assessment dated 5/11/16 indicated C6 was vulnerable for abuse due to the inability to verbalize his needs. During an interview with ULP-J on 6/14/16, at 3:35 p.m. stated ULP-H had sent her pictures of C6 via text message and snap chat and thought this had occurred between December 2015 and January 2016 . An on-site investigation was completed on 6/14/16 and 6/15/16 for an allegation of abuse. The allegation was not self reported by the licensee. During an interview with ULP-J on 6/14/16, at 3:35 p.m. she stated she saw ULP-H taking pictures of clients. During an interview with the House Manager on 6/14/16, at 1:35 p.m. she stated there was inappropriate picture taking occurring on the evening shift while she was a lead caregiver. She stated a staff member reported that an evening staff member sent a picture of one of the clients through text message. She stated she did confront ULP-H who did admit to taking pictures of the clients. The House Manager stated she did not ask to see the picture and told the staff to delete it. She stated she reported it to the housing manager at the time and the housing manager instructed her to educated the staff on the cell phone policy. The House Manager was unsure if the housing manager at the time filed a vulnerable adult report and was unable to provide any reports or investigation related to the	02015		

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	H23369	A. BUILDING: _____ B. WING _____	C 07/06/2016

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HUGO GW LLC	5607 NORTH 150TH STREET HUGO, MN 55038

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02015	Continued From page 21 allegation The licensee form titled "Resident Photographic Release" states photographs and video recordings taken by an employee will be used for internal postings only and for advertising/publication of the licensee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		
02030 SS=I	626.557, Subd. 4a Internal Reporting of Maltreatment 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. (b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common	02030		

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02030	Continued From page 22 entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally. This MN Requirement is not met as evidenced by: Based on interview, document review and video/photographic evidence the licensee staff failed to initiate an internal investigation after receiving reports of staff using cell phones to take pictures of clients for six of six clients (C1, C2, C3, C4, C5, C6). 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 serious injury, impairment, or death); and, is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on 12/20/11 with diagnoses that included dementia. The service plan dated 5/10/16 indicated C1 required assistance for all activities of daily living (ADL's) including medication administration. The vulnerability assessment dated 3/23/16 indicated C1 was vulnerable for abuse related to dementia	02030		

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02030	Continued From page 23 and making nonsensical speech. During an interview with with unlicensed personnel (ULP)-M on 6/21/16, at 3:10 p.m. she stated she saw a video of C1 on the toilet on ULP-H's cellphone. ULP-M stated ULP-J was in the video and ULP-H recorded it. ULP-M stated C1 said "you guys are going to go to hell" and either ULP-H or ULP-J said "we'll see you there." ULP-M stated she also received a video from ULP-L through a facebook (social media) message. ULP-M stated the video was of C1 taken by ULP-L sitting on the toilet, yelling at the licensee staff. ULP-M stated ULP-L had sent her a message with the video stating, C1 is mad and will not let anyone help her with cares C2's medical record was reviewed. C2 was admitted to the licensee on 6/14/12 with diagnoses that included Alzheimer's. The service plan dated 1/5/15 indicated the client required assistance for all ADL's including medication administration. C2 ambulates independently. The vulnerability assessment dated 7/10/15 indicated C2 was vulnerable for abuse related to dementia and the inability to recall events and report maltreatment. Video evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. The video was of C2, sitting in a wheelchair at a table. C2 had a white shirt on. C2 had a white powdered substance spread under his nose and the same white powdered substance was placed on the table in three separate straight lines. The video had the song "Cocaine" by Eric Clapton playing in the background and C2 was having arm tremors. During an interview with with ULP-M on 6/21/16,	02030		

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02030	Continued From page 24 at 3:10 p.m. she stated ULP-H showed her two videos of C2 taken by ULP-H on ULP-H's cellphone. ULP-M stated the first video was of C2 holding an empty alcohol bottle. A staff member (unsure who) was pushing C2 in his wheelchair and rock music was playing in the background. ULP-M stated ULP-H told her she found the empty alcohol bottle outside. ULP-M stated the second video was of C2. C2 was sitting in a wheelchair at the table, had powdered sugar on the table in lines and under his nose. ULP-M stated it looked like C2 was doing cocaine. During an interview with ULP-J on 6/14/16, at 3:35 p.m. she stated ULP-H sent her pictures of C2 via text message and snap chat (social media). ULP-J stated she thought this had occurred between December 2015 and January 2016. ULP-J stated she received the video of C2 on 4/17/16 from ULP-I displaying powdered sugar on his nose and lines of powdered sugar to look like cocaine. ULP-J stated ULP-H and ULP-I were working the night the video was taken, but she was unsure who took the video. ULP-J stated she's also seen a video of C2 with a bottle vodka that ULP-H had brought into the licensee and gave to C2. ULP-J stated she knew taking a video of C2 was wrong, but did not report because ULP-H was her friend and ULP-I was her brother. During an interview with ULP-K on 6/14/16, at 3:00 p.m. she stated she received a picture of C2 from ULP-H. C2 was dressed in a grey sweatshirt with a hat on. ULP-K stated she received pictures of on snap chat from ULP-I and ULP-J. ULP-K could not recall when she received the pictures. ULP-K stated she took a picture of C2 and herself. ULP-K stated C2 was dressed in normal clothes and she did not send it to anyone else.	02030		

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02030	Continued From page 25 C3's medical record was reviewed. C3 was admitted to the licensee on 7/31/2014 with diagnoses that included dementia. The service plan dated 5/11/16 indicated C3 required assistance with dressing, grooming and medications and cues for all other ADL's. The vulnerability assessment dated 8/6/15 indicated C3 was vulnerable for abuse due to a poor historian and would not be capable of accurately reporting abuse. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. One photo was taken by ULP-J on her personal cellphone of C3. The photograph of C3, dressed in a grey shirt, with ULP-J to her left and ULP-I standing behind her. C3 and ULP-I both had a lollipop in their mouths and ULP-J was holding a lollipop next to her mouth. During an interview with ULP-J on 6/14/16 at 3:35 p.m. stated that she had taken pictures of C3 and thought pictures were taken between December 2015 and January 2016. C4's medical record was reviewed. C4 was admitted to the licensee on 10/14/15 with diagnoses that included Crohn's disease. The service plan dated 10/14/15 indicated C4 required assistance with all ADL's including medications. The vulnerability assessment dated 10/14/15 indicated C4 had identified areas of vulnerability due to being hard of hearing. Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. One photo was taken by ULP-J on her personal cellphone of C4. The	02030		

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02030	Continued From page 26	02030		

photograph showed C4 wearing a stripped, turtle neck sweater with ULP-J to her right and ULP-I to her left. They were all smiling in the photo.

During an interview with ULP-K on 6/14/16 at 3:00 p.m. stated she received pictures of C3 and C4 on snap chat from ULP-I and ULP-J but was unsure when.

C5's medical record was reviewed. C5 was admitted to the licensee on 4/1/13 with diagnoses that included dementia. The service plan dated 5/10/16 indicated C5 required assistance with all ADL's including medications. The vulnerability assessment dated 4/6/16 indicated C4 was vulnerable for abuse due to dementia and inability to report abuse/neglect.

Photographic evidence was received and reviewed on 6/14/16 from ULP-J during the on-site investigation. Two photos were taken by ULP-J on her personal cellphone of C5. The photographs of C5 were of her alone, sitting in a wheelchair, holding a doll. C5 was wearing a white t-shirt with black stripes and grey pants.

During an interview with ULP-J on 6/14/16 at 3:35 p.m. stated ULP-H had sent her pictures of C4 and C5 via text message and snap chat. ULP-J stated that she had taken pictures of C4 and C5 and thought this had taken place between December 2015 and January 2016.

C6's medical record was reviewed. C6 was admitted to the licensee on 9/30/15 with diagnoses that included Lewy body dementia and Alzheimer's disease. The service plan dated 5/11/16 indicated C6 required assistance with all ADL's including medications. The vulnerability assessment dated 5/11/16 indicated C6 was

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02030	Continued From page 27 vulnerable for abuse due to the inability to verbalize his needs. During an interview with ULP-J on 6/14/16 at 3:35 p.m. stated ULP-H had sent her pictures of C6 via text message and snap chat and thought this had occurred between December 2015 and January 2016 . An on-site investigation was completed on 6/14/16 and 6/15/16 for an allegation of abuse. The allegation was not self reported by the licensee. During an interview with ULP-J on 6/14/16, at 3:35 p.m. she stated she saw ULP-H taking pictures of clients. During an interview with the House Manager on 6/14/16, at 1:35 p.m. she stated there was inappropriate picture taking occurring on the evening shift while she was a lead caregiver. She stated a staff member reported that a evening staff member sent a picture of one of the clients through text message. She stated she did confront ULP-H who did admit to taking pictures of the clients. The House Manager stated she did not ask to see the picture and told the staff to delete it. She stated she reported it to the House Manager at the time and the House Manager instructed her to educated the staff on the cellphone policy. She was unsure if the house manager at the time filed a vulnerable adult report. She stated she did educate the staff and made herself more present on the evening shift. The licensee policy titled Vulnerable Adult Reporting and Investigation Policy dated 1/27/16, states if it is unclear whether maltreatment has occurred, the RN in coordination with the house	02030		

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02030	Continued From page 28 manager will immediately begin investigating the incident upon hearing report of the incident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02030		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 16, 2017

Ms. Rhonda Schillinger, Administrator
Hugo GW LLC
5607 North 150th Street
Hugo, MN 55038

RE: Complaint Number HL23369006

Dear Ms. Schillinger :

On May 30, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on July 6, 2016 with orders received by you on October 3, 2016. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

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

MH/ja

Enclosure

cc: Home Health Care Assisted Living File
Washington County Adult Protection
Office of Ombudsman
MN Department of Human Services