*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** HL24584005M
**Compliance #:** HL24584006C

**Date Concluded:** January 22, 2020

**Name, Address, and County of Licensee Investigated:**
Pleasant View Estates, LLC
41 Brand Avenue
Faribault, MN 55021
Rice County

**Facility Type: Home Care Provider**

**Investigator's Name:** Christine Bluhm, R.N.
Special Investigator

**Finding: Substantiated, individual responsibility**

**Nature of Visit:**
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

**Allegation(s):**
It is alleged: Neglect occurred when the alleged perpetrator (AP) failed to do wellness checks on the client. The AP served the client his meal tray while the client sat in soiled clothing and chair. The client also was found to be soiled on other occasions upon transfer and evaluation at the hospital.

**Investigative Findings and Conclusion:**
Neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to provide the client with his scheduled services and hygiene cares, which led to the client being left in a soiled condition. The client subsequently developed a pressure ulcer. The AP demonstrated a pattern of not providing cares for clients as scheduled.

The investigation included interviews with facility staff, nursing staff, and unlicensed staff. The investigation included a review of policies and procedures and staff training records. Employee personnel files were reviewed for appropriate licenses and backgrounds. Several client medical

records were reviewed, including the client's record. Interviews with multiple clients and families found related issues.

The client's diagnoses included high blood pressure, history of alcohol abuse, lung disease, urinary retention with indwelling urinary catheter, intracranial injury with loss of consciousness and falls. The client received home care services for bathing; urinary catheter care; toileting; meal set-up; laundry and linen changes; housekeeping; behavior support as needed; and medication administration. The client used a walker and required assistance with walking. The client had intermittent confusion and could not always use the call button to request help from staff.

Review of the AP's employment file indicated the AP received warning notices for being non-compliant with client services. A warning notice indicated a family member expressed concerns regarding the condition the client was in when he was served his meal tray. The client was not wearing pants and had dried feces on his skin, clothing, recliner and floor. Interviews and service documentation indicated that the AP had not checked on the client at his scheduled reassurance checks that day. The facility also issued corrective action to the AP when she did not provide showers to two other clients according to their service agreements, was not timely with medications, not answering call lights in a timely manner, was found loitering in client rooms, and exhibited rude behavior towards clients.

Review of the facility nursing progress notes indicated the client developed a Stage 2 pressure ulcer on his buttocks.

Review of the client's hospitalization notes indicated the client was evaluated in the emergency department on three separate occasions. On each occasion, the client was noted to have dried feces on his skin, under his fingernails, and on his clothing. Emergency responders noted the client and his apartment to be unkept and soiled on multiple occasions.

Review of the AP's written statement from the facility's internal investigation indicated she checked on the client the morning the client's family complained about the client's condition and made sure the client was cleaned up after soiling himself. The AP wrote she delivered all of the clients' meal trays, including the client's tray, and went back to check on the client, but at that time, his family had arrived to see the client.

Review of the staff schedule on the date of the incident, indicated the AP was the unlicensed staff assigned to care for the client. The nurse on-call was available as a resource to the AP. The AP did not report the client's condition.

The AP declined a full interview during this investigation.

During interview, several staff members stated the AP would not respond to call lights in a timely manner or sometimes not at all. The AP would disappear during the shift or training of new staff and could not be found. The AP could be rude to clients.

During interview, the facility nurse consultant stated that the AP did not check on the client according to his service agreement which led to the client being left in a soiled condition and developing skin breakdown on his backside. The client was prescribed an antibiotic that may have contributed to his loose stool incontinence. The nurse consultant also stated and she had worked the day of the reported incident and administered medications to clients. The AP did not report the client's soiled condition to the nurse. The nurse stated two other clients also complained of not receiving a shower on their scheduled bath day. She stated that the common denominator was the AP, who was assigned on those dates.

On the day of the incident, the AP was the only staff member scheduled. However, the AP still gave the client his meal tray in his soiled condition without any attempt at providing hygiene care or asking for assistance from the on-call nurse.

During interview, a witness stated that there was not enough staff scheduled to provide all the needs of the clients, and bathing and hygiene needs were not consistently being met. The witness could not confirm if the AP was responsible.

In conclusion, neglect was substantiated. Due to the AP's inaction, the client's scheduled services, which included basic bathing and hygiene needs, were not met.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

**Vulnerable Adult interviewed**: No. The VA is deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes, contact was made with the AP, but the AP declined a full interview.

**Action taken by facility:**
The client's service plan was updated to reflect the client's increased toileting needs. The AP no longer worked at the facility.

**Action taken by the Minnesota Department of Health:**
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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.

cc: The Office of Ombudsman for Long-Term Care
Rice County Attorney
Faribault City Attorney

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>On January 7, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL24584005M/#HL24584006C. At the time of the survey, there were #32 clients receiving services under the comprehensive license.<br><br>The following correction orders are issued for #HL24584005M/#HL24584006C, tag identification 0320, 0325 and 0865. | 0 000 | The Minnesota Department of Health documents 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 requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b). | |
| 0 320 SS=D | 144A.44, Subd. 1(13) Treated With Respect<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights: | 0 320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 320 | Continued From page 1<br>(13) the right to be treated with courtesy and respect, and to have the client's property treated with respect;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure 2 of 4 clients (C1, C2) reviewed were treated with dignity and respect. C1 did not receive proper incontinence and hygiene care prior to being served his meal and on three other separate times upon transport to the hospital. C2's soiled incontinence products were not removed by staff from her bathroom which caused a strong urine odor in her apartment.<br><br>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), 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).<br><br>Findings include:<br><br>C1's medical record was reviewed. C1 most recent nursing assessment dated May 28, 2019, indicated C1 required hands on assistance with toileting and bathing.<br><br>C1's service agreement dated July 30, 2019, indicated C1 had diagnoses that included hypertension, alcohol abuse, intracranial injury with loss of consciousness, cognitive communication deficit, and weakness. C1 | 0 320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 320 | Continued From page 2<br><br>received supervised care level seven with morning and evening cares, catheter bag changes daily, assistance with bathing, behavioral support, cues to meals, laundry, housekeeping, medication administration, ambulation assistance and toileting. Staff were instructed to provide reassurance checks at 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., 10:00 p.m., 12:00 a.m., 2:00 a.m., and 4:00 a.m. During those times, staff were supposed to request that C1 stand up or reposition to ensure C1 was not sitting in soiled items.<br><br>C1's nursing progress note dated July 22, 2019 at 3:52 p.m., indicated C1 went to the hospital for urinary catheter reinsertion. On July 20, 2019, Emergency Room (ER) staff contacted family member (FM)-F by phone and questioned why dried bowel movement (BM) was on C1's back. The note also indicated FM-F stated that when she visited the day prior on July 21, 2019, at 1:00 p.m., C1 was eating his meal with no pants on and had dried BM down his recliner, on the carpet, and on a towel on the floor indicating C1 had been given a towel. At the time, C1 stated to FM-F that unlicensed personnel (ULP)-B delivered his meal tray at 12:30 p.m. According to the service agreement, C1 was scheduled for reassurance check at 12:00 p.m.<br><br>C1's ER physician note dated July 29, 2019, indicated while in the ER, C1 was observed lying in dried BM with a wristband still on from his hospital visit nine days prior.<br><br>C1's ER nurses note dated July 29, 2019 at 11:06 p.m., indicated C1 had BM on his feet, legs, hands, and under his finger nails upon arrival to the ER. Emergency Medical Services (EMS) | 0 320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 320 | Continued From page 3<br><br>responders stated that C1 was found lying in feces at the facility. EMS stated that there was feces on the floor, and the bathroom was a "mess." C1 had pulled out his Foley catheter and was incontinent.<br><br>C1's nursing progress note dated August 1, 2019 at 3:01 p.m., indicated FM-F called the facility regarding follow-up from the hospital. Despite efforts from facility to increase toileting assistance, C1 continued to have loose stools and was found intermittently with BM on his skin.<br><br>During interview on January 3, 2020, at 4:33 p.m., FM-F stated that when she would go visit C1 on her lunch and after work, he would be sitting in the same position and would not have been moved. C1 needed assistance to the bathroom. She stated he was unsteady. C1 told staff he did not need a shower so they were not giving him one so FM-F started helping with all of C1's showers. She stated there might have been one or two times that staff gave C1 a shower. FM-F stated C1 was not getting the care he should have.<br><br>During interview on January 8, 2020, at 3:15 p.m., a hospital staff member stated C1 was observed to be covered with BM on visits to the ER two days in a row.<br><br>During interview on January 9, 2020, registered nurse (RN)-A stated that C1's pressure ulcers were the result of C1's diarrhea episodes and sedentary lifestyle. C1 was on antilbiotics. RN-A stated that C1 was not checked per his service agreement by ULP-B on July 21, 2019 when FM-F found C1 soiled with BM and his meal tray in front of him. RN-A stated ULP-B was supposed to be in C1's room every 2 hours | 0 320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 320 | Continued From page 4<br><br>according to C1's service plan. RN-A stated the reassurance check was supposed to be done at noon by ULP-B (she was assigned as PCA 1). ULP-B was not going in and confirming her IPOD (electronic reminder device). The system manually documented the entry. RN-A stated IPOD assessments are determined when the nurse completes the assessment, creates the service agreement, and then this kicks out into the IPOD for assignment. RN-A stated two other clients (C4, C5) complained about not receiving a shower on their scheduled bath day. RN-A stated that the common denominator was ULP-B, who was assigned on those dates.<br><br>C2's medical record was reviewed. C2's service agreement dated January 7, 2020, indicated C2 diagnoses included osteoarthritis, dysphagia, and macular degeneration. C2 received services for assessments, vital signs, meal assistance, housekeeping, laundry, and supervision with bathing, hygiene, toileting and ambulation. As of effective date November 21, 2019, C2 had increased incontinence, which required complete peri-care, changing of incontinence products, and making sure C2 had clean/dry clothing on. Staff were supposed to remove her soiled garbage and wash any soiled laundry. Time checks were supposed to be done at 7:30 a.m. and 11:30 a.m.<br><br>During observations on January 7, 2020 at 11:00 a.m., C2 was interviewed in her apartment. C2 stated she had received staff assistance with her shower that morning. Upon entry into C2's apartment, a strong smell of urine was present. Upon inspection of C2's bathroom, the garbage had several urine soaked incontinence pads.<br><br>During observation son January 7, 2020 at 1:50 p.m., C2's apartment was inspected. The | 0 320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 320 | Continued From page 5<br><br>apartment still smelled of urine, and the urine soaked incontinence pads were still in the garbage.<br><br>During interview on January 7, 2020 at 3:00 p.m., RN-A was informed of the strong urine odor in C2's apartment and garbage in C2's bathroom. RN-A stated that C2's service plan included that incontinence pads should have been discarded during the scheduled check.<br><br>During interview on January 13, 2020, at 9:15 a.m., FM-G stated that there was one time when C2 went up to two weeks without a shower, and FM-G complained.<br><br>Policy titled Monarch Healthcare Infection Control, undated, indicated that proper hand washing technique is the number one step you can take to prevent the spread of infection. Hand washing should be completed:<br>Before, during, and after preparing food<br>Before eating food<br>Before and after caring for someone who is sick<br>Before and after treating a cut or wound<br>After using the toilet<br>After changing diapers or cleaning up after someone who has used the toilet<br>Antibiotic use is the greatest risk factor for Clostridium difficile infections (C. diff) in the elderly in long-term care facilities. C.diff bacteria is shed in the stool, any surface that becomes contaminated with the feces may become a reservoir for the C. diff and the spores of C. diff can live on surfaces for extended periods (up to 5 months). C.diff may be found on things in the environment such as bed linens, bed rails, bathroom fixtures, hallway rails and medical equipment. It can spread from person-to-person on contaminated equipment and on the hands of | 0 320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 320 | Continued From page 6<br><br>doctors, nurses, other healthcare providers and visitors.C. diff can spread from person-to-person on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors.<br><br>Time period for correction: Seven (7) days. | 0 320 | | |
| 0 325 | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights:<br>(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms<br>of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, the facility failed to ensure one of four clients reviewed (C1) was free from maltreatment. C1 was neglected.<br><br>Findings include:<br><br>On January 22, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred. | 0 325 | No plan of correction is required. Please refer to the maltreatment public report for details. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 7 | 0 865 | | |
| 0 865 SS=D | 144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions<br><br>Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan.<br><br>(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.<br><br>(c) The home care provider must implement and provide all services required by the current service plan.<br><br>(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.<br><br>(e) Staff providing home care services must be informed of the current written service plan. | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide complete incontinence and bathing care in accordance with the service plan for 2 of 4 clients (C1, C2) reviewed. C1 did not receive proper incontinence and hygiene care according to his service plan prior to being served his meal and three other separate times upon transport to the hospital. C2's soiled incontinence products were not removed from her bathroom with her scheduled check according to her service agreement which caused a strong urine odor in her apartment. C1 and C2 were not bathed according to their respective service plans.<br><br>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), 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).<br><br>Findings include:<br><br>C1's medical record was reviewed. C1's most recent assessment dated May 28, 2019, indicated C1 required hands-on assistance with toileting and bathing.<br><br>C1's service agreement dated July 30, 2019, indicated C1 had diagnoses that included hypertension, alcohol abuse, intracranial injury with loss of consciousness, cognitive communication deficit, and weakness. C1 received supervised care level seven with | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 9<br><br>morning and evening cares, catheter bag changes daily, assistance with bathing, behavioral support, cues to meals, laundry, housekeeping, medication administration, ambulation assistance and toileting. Staff were instructed to provide reassurance checks at 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., 10:00 p.m., 12:00 a.m., 2:00 a.m., and 4:00 a.m. During those times, staff were supposed to request that C1 stand up or reposition to ensure C1 was not sitting in soiled items.<br><br>C1's nursing progress note dated July 22, 2019 at 3:52 p.m., indicated C1 went to the hospital for urinary catheter reinsertion. On July 20, 2019, Emergency Room (ER) staff contacted family member (FM)-F by phone and questioned why dried bowel movement (BM) was on C1's back. The note also indicated FM-F stated that when she visited the day prior on July 21, 2019, at 1:00 p.m., C1 was eating his meal with no pants on and had dried BM down his recliner, on the carpet, and on a towel on the floor indicating C1 had been given a towel. At the time, C1 stated to FM-F that unlicensed personnel (ULP)-B delivered his meal tray at 12:30 p.m. According to the service agreement, C1 was scheduled for a reassurance check at 12:00 p.m.<br><br>C1's ER physician note dated July 29, 2019, indicated while in the ER, C1 was observed lying in dried BM with a wristband still on from his hospital visit nine days prior.<br><br>C1's ER nurses note dated July 29, 2019 at 11:06 p.m., indicated C1 had BM on his feet, legs, hands, and under his finger nails upon arrival to the ER. Emergency Medical Services (EMS) responders stated that C1 was found lying in | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 10<br><br>feces at the facility. EMS stated that there was feces on the floor, and the bathroom was a "mess." C1 had pulled out his Foley catheter and was incontinent.<br><br>C1's nursing progress note dated August 1, 2019 at 3:01 p.m., indicated FM-F called facility regarding follow-up from the hospital. Despite efforts from facility to increase toileting assistance, C1 continued to have loose stools, and was found intermittently with BM on his skin.<br><br>During interview on January 3, 2020, at 4:33 p.m., FM-F stated that when she would go visit C1 on her lunch and after work, he would be sitting in the same position and would not have been moved. C1 needed assistance to the bathroom. She stated he was unsteady. C1 told staff he did not need a shower so they were not giving him one so FM-F started helping with all of C1's showers. She stated there might have been one or two times that staff gave C1 a shower. FM-F stated C1 was not getting the care he should have.<br><br>During interview on January 8, 2020, at 3:15 p.m., a hospital staff member stated C1 was observed to be covered with BM on visits to the ER two days in a row.<br><br>During interview on January 9, 2020, registered nurse (RN)-A stated that C1's pressure ulcers were the result of C1's diarrhea episodes and sedentary lifestyle. C1 had been on antibiotics. RN-A stated that C1 was not checked per his service agreement by ULP-B on July 21, 2019 when FM-F found C1 soiled with BM and his meal tray in front of him. RN-A stated ULP-B was supposed to be in C1's room every 2 hours according to C1's service plan. RN-A stated the | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 11<br><br>reassurance check was supposed to be done at noon by ULP-B (she was assigned as PCA 1). ULP-B was not going in and confirming her IPOD (electronic reminder device). The system manually documented the entry. RN-A stated IPOD assessments are determined when the nurse completes the assessment, creates the service agreement, and then this kicks out into the IPOD for assignment. RN-A stated two other clients (C4, C5) complained about not receiving a shower on their scheduled bath day. RN-A stated that the common denominator was ULP-B, who was assigned on those dates. C4 was of with sound mind, and identified ULP-B as the individual.<br><br>C2's medical record was reviewed. C2's service agreement dated January 7, 2020, indicated C2 diagnoses included osteoarthritis, dysphagia, and macular degeneration. C2 received services for assessments, vital signs, meal assistance, housekeeping, laundry, and supervision with bathing, hygiene, toileting and ambulation. As of effective date November 21, 2019, C2 had increased incontinence, which required complete peri-care, changing of incontinence products, and making sure C2 had clean/dry clothing on. Staff were supposed to remove her soiled garbage and wash any soiled laundry. Time checks were supposed to be done at 7:30 a.m. and 11:30 a.m.<br><br>During observations on January 7, 2020 at 11:00 a.m., C2 was interviewed in her apartment. C2 stated she had received staff assistance with her shower that morning. Upon entry into C2's apartment, a strong smell of urine was present. Upon inspection of C2's bathroom, the garbage had several urine soaked incontinence pads.<br><br>During observation son January 7, 2020 at 1:50 | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 12<br><br>p.m., C2's apartment was inspected. The apartment still smelled of urine, and the urine soaked incontinence pads were still in the garbage.<br><br>During interview on January 7, 2020 at 3:00 p.m., RN-A was informed of the strong urine odor in C2's apartment and garbage in C2's bathroom. RN-A stated that C2's service plan included that incontinence pads should have been discarded during the scheduled check.<br><br>During interview on January 13, 2020, at 9:15 a.m., FM-G stated that there was one time when C2 went up to two weeks without a shower, and FM-G complained.<br><br>Policy titled Monarch Healthcare Infection Control, undated, indicated that proper hand washing technique is the number one step you can take to prevent the spread of infection. Hand washing should be completed:<br>Before, during, and after preparing food<br>Before eating food<br>Before and after caring for someone who is sick<br>Before and after treating a cut or wound<br>After using the toilet<br>After changing diapers or cleaning up after someone who has used the toilet<br>Antibiotic use is the greatest risk factor for Clostridium difficile infections (C. diff) in the elderly in long-term care facilities. C.diff bacteria is shed in the stool, any surface that becomes contaminated with the feces may become a reservoir for the C. diff and the spores of C. diff can live on surfaces for extended periods (up to 5 months). C.diff may be found on things in the environment such as bed linens, bed rails, bathroom fixtures, hallway rails and medical equipment. It can spread from person-to-person | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H24584 | A. BUILDING: _____ B. WING _____ | C 01/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PLEASANT VIEW ESTATES LLC | 41 BRAND AVENUE FARIBAULT, MN 55021 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 13<br>on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors.C. diff can spread from person-to-person on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors<br><br>Time period for correction: Seven (7) days. | 0 865 | | |