



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Elmhurst Commons
400 3rd Street Southwest
Braham, Minnesota 55006
Isanti County

Report #: HL24848002

Date: May 29, 2014

Date of Visit: April 15 and 16, 2014
Time of Visit: 8:30 a.m.-3:30 p.m. &
1:00 p.m.-5:00 p.m.

By: Lisa Jacobsen, R.N., Special Investigator
Darin Hatch, Special Investigator

- Type of Facility:**
- Nursing Home
 - SLF
 - Hospital
 - HHA
 - ICF/IID
 - Other: _____
 - Home Care Provider/Assisted Living
 - Home Care

- Facility Self Report
- Complaint

Allegation(s): It is alleged that a staff, alleged perpetrator (AP) took a client's medications.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Licensing Rules for Home Care (MN Rules Chapter 4668)
- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)

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

State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

Abuse Neglect Financial Exploitation was:

Substantiated Not Substantiated Inconclusive based on the following information:

The preponderance of evidence established that financial exploitation occurred when the AP took three oxycodone tablets (a narcotic medication) that belonged to the client, without the client's permission.

The client was identified as having occasional memory loss and received assistance with medication administration. The client had a physician's order for oxycodone 5 milligrams to be taken as needed for pain.

Surplus narcotic medications for clients were stored in the nurse's office in a locked drawer in a locked medication cart until the medication needed to be replaced in the client's apartment medication storage cupboard.

The client had a surplus bubble pack card of 16 oxycodone 5 milligram tablets that was stored in a locked drawer in the locked medication cart. A witness observed the AP take the keys to the narcotic drawer out of a nurse's bag, open the narcotic drawer, take one of the bubble pack cards out of the narcotic drawer and placed the bubble pack medication card in her/his (the AP's) handbag. The AP left the nurse's office. The witness along with another nurse looked in the AP's handbag and noted the client's bubble pack card of oxycodone 5 milligrams. The AP returned to the nurse's office and took her/his handbag into the bathroom. When the AP came out of the bathroom s/he was confronted about taking the client's bubble pack card of oxycodone. The AP initially denied taking the client's bubble pack medication card, but when told the police would be called, the AP returned the client's card to the narcotic drawer. Three tablets of the client's oxycodone 5 milligrams were missing from the bubble pack card of 16 tablets. When questioned by staff as to why s/he would take the client's oxycodone, the AP stated s/he could not handle everything that was going on with one of the clients. The AP stated s/he flushed the three tablets belonging to the client down the toilet. The AP stated this was the first time s/he had taken any clients' medications.

The police report indicated the AP was interviewed and admitted to taking two oxycodone tablets from the client. The AP stated that when s/he "got caught," it was her/his first time taking the oxycodone.

The client was interviewed at the time of the onsite investigation and indicated s/he was not aware that any of her/his oxycodone tablets had been taken until the morning of the onsite investigation. The client stated s/he requested oxycodone when s/he had leg pain.

The AP declined to be interviewed at the advice of her/his attorney.

The AP was terminated from working at the facility the day the client's oxycodone was taken.

The investigation revealed additional narcotic medications that belonged to other clients were reported missing over a period of 11 months. It could not be determined who took the other clients' narcotic medications, as the

facility's control of narcotics and narcotic record keeping were lacking. State licensing correction orders were issued related to this.

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:

Although the home care provider was not in compliance with regulatory standards related to the control of narcotics and training, the AP had extensive nursing training as s/he completed the requirements to be a registered nurse. The home care provider had policies in place to govern the handling and control of narcotic medications and the consequences of theft from clients. The AP's personnel file showed the AP's acknowledgement of receiving the "Employee Handbook" which indicated "theft or inappropriate removal or possession of property" was unacceptable in the workplace. The AP did not follow professional standards in exercising professional judgment when s/he took medications belonging to the client without the client's permission.

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

Compliance:**State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Not Met**

The requirements under State Licensing Rules for Home Care (MN Rules Chapter 4668) were not met.

State licensing orders were issued: Yes No If no, specify: _____

(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 If no, specify: _____

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

Definitions: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.

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

The Investigation included the following:**Document Review: The following records were reviewed during the investigation:**

- | | |
|--|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input checked="" type="checkbox"/> Medication Administration Records | <input checked="" type="checkbox"/> Treatment Sheets |
| <input checked="" type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input checked="" type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input type="checkbox"/> Social Service Notes |
| <input checked="" type="checkbox"/> Nurses Notes | <input type="checkbox"/> Meal Intake Records |
| <input type="checkbox"/> Activities Reports | <input type="checkbox"/> Weight Records |
| <input type="checkbox"/> Therapy and/or Ancillary Services Records | <input checked="" type="checkbox"/> Assessments |
| <input type="checkbox"/> Skin Assessments | <input checked="" type="checkbox"/> Care Plan Records |

Other pertinent medical records:

- Hospital Records Ambulance/Paramedics Medical Examiner Records Death Certificate

Police Report

Additional facility records:

Resident/Family Council Minutes

Personnel Records/Background Check, etc.

Staff Time Sheets, Schedules, etc.

Facility In-service Records

Facility Internal Investigation Reports

Facility Policies and Procedures

Call Light Audits

Other, specify: _____

Number of additional resident(s) reviewed: 7

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: Facility Self-Report

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: 6

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

Tennessee Warning given as required: Yes No

Total number of staff interviews: 5

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: Declined interview at the advice of her/his attorney.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: Yes , date subpoena was issued _____ No

Were contacts made with any of the following:

Emergency personnel Police Officers Medical Examiner Other: Specify _____

Observations were conducted related to:

- Wound Care Medication Pass Meals
- Personal Care Dignity/Privacy Issues Restorative Care
- Nursing Services Safety Issues Facility Tour
- Infection Control Cleanliness Injury
- Use of Equipment Transfers Incontinence
- Call Light Other: Narcotic Storage

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: Medication Storage

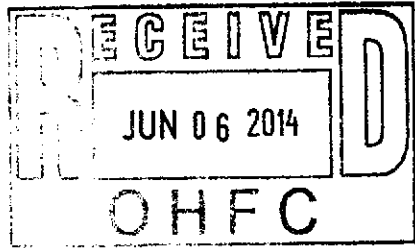
xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Nursing
Osseo City Police Department
Hennepin County Attorney
Osseo City Attorney


Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H24848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
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NAME OF PROVIDER OR SUPPLIER ELMHURST COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 400 3RD STREET SOUTHWEST BRAHAM, MN 55006
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0 000	<p>Initial comments</p> <p>A complaint investigation was initiated to investigate case #HL24848002. The following correction orders are issued.</p> <p>When corrections are completed please sign and date, make a copy of the form for your records and return the original to the MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule out of compliance is listed in the "Summary Statement of Deficiencies" column. 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
0 605	<p>626.557 Subd.3 Timing of report</p> <p>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</p>	0 605		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE - President Vision Quest property mgmt.	(X6) DATE 6-5-14
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0 605	<p>Continued From page 1</p> <p>reasonably explained shall immediately report the information to the common entry point. If an 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:</p> <p>(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</p> <p>(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).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(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.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(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</p>	0 605		

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0 605	<p>Continued From page 2</p> <p>the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or 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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that incidents of possible exploitation were reported immediately to the common entry point for six of nine clients (C2, C3, C4, C5, C6 and C7) reviewed. The findings included:</p> <p>A document dated April 2, 2014 signed by registered nurse (RN)-C indicated that on March 14, 2014, it was noted that a "whole card" of oxycodone (an opioid narcotic pain medication) 5 milligrams 1/2 tablets that belonged to C5 were unaccounted for except for two tablets left on the card.</p> <p>A document dated April 2, 2014 signed by RN-C indicated that on March 18, 2014, it was noted that C4 was missing one tablet of oxycodone 5 milligrams.</p> <p>A document dated April 2, 2014 signed by RN-C indicated that on March 24, 2014, it was noted</p>	0 605		

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0 605	<p>Continued From page 3</p> <p>that C6 was missing two tablets of oxycodone 5 milligrams.</p> <p>A document titled "Investigative Report" (undated) indicated that on January 19, 2014, C7 had the medication dilaudid (an opioid narcotic pain medication) delivered from the pharmacy. A week later, it was noted that C5 was short three days of the dilaudid.</p> <p>When interviewed April 25, 2014 at 10:10 a.m., RN-C confirmed C4, C5, C6, and C7 had narcotic medications that were missing. RN-C indicated it was not determined who may have taken the missing narcotics. In addition, RN-C stated that sometime in June or July of 2013, someone had replaced C2's vicodin (an opioid narcotic pain medication) with Tylenol. And in May or June of 2013, C3's physician discontinued C3's oxycodone. C3's oxycodone was stored in a narcotic drawer to be destroyed later, but then was missing. RN-C indicated these incidents of missing narcotics were not reported to the common entry point.</p> <p>The licensee's policy titled "Vulnerable Adult Reporting" which was undated, indicated the following; "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.."</p> <p>TIME PERIOD FOR CORRECTION: Thirty (30) days</p>	0 605		
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06040	Continued From page 4	06040		
06040	<p>4668.0805 Subp, 1 Orientation to HC Requirement</p> <p>Subpart 1. Orientation. An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that staff who provided direct care and supervision of direct care completed an orientation to home care requirements before providing home care services to clients for five of five (B, C, D, E and F) personnel files reviewed. The findings included:</p> <p>Employees B, C, D, E and F were hired, to provide direct care and/or supervise direct care in April 2006, January 2008, December 2012, January 2000 and May of 2013 respectively.</p> <p>There was no evidence in Employees B, C, D, E and F's personnel files that they completed an orientation to the home care requirements that included: an overview of Minnesota Rules 4668 and Minnesota Statutes, sections 144A.43 to 144A.47; handling emergencies and using emergency services; reporting the maltreatment</p>	06040		

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06040	<p>Continued From page 5</p> <p>of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557; the home care bill of rights, Minnesota Statutes, section 144A.44; handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and the services of the ombudsman for older Minnesotans.</p> <p>When interviewed, April 15, 2014 at 1:30 p.m., Employee A/Housing Director confirmed that Employees B, C, D, E and Fs' training did not include an orientation to the home care requirements.</p> <p>TIME PERIOD FOR CORRECTION: Thirty (30) days</p>	06040		
06385	<p>4668.0865 Subp. 3 Control of Medications</p> <p>Subp. 3. Control of medications.</p> <p>A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.</p> <p>B. The system must contain at least the following provisions:</p> <p>(1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;</p> <p>(2) a description of how the distribution and storage of medications will be handled, including</p>	06385		

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06385	<p>Continued From page 6</p> <p>a description of suitable storage facilities;</p> <p>(3) the procedures for recording medications that clients are taking;</p> <p>(4) the procedures for storage of legend and over-the-counter drugs;</p> <p>(5) a method of refrigeration of biological medications; and</p> <p>(6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain a system for the control of narcotic medications for six of nine clients (C2, C3, C4, C5, C6 and C7) reviewed, who received narcotic medications. The findings included:</p> <p>Narcotic medications belonging to clients were unaccounted for and staff were unable to determine exactly when the narcotics were taken and/or who may have taken the narcotic medications.</p> <p>A document dated April 2, 2014 signed by registered nurse (RN)-C indicated that on March 14, 2014, it was noted that a "whole card" of oxycodone (an opioid narcotic pain medication) 5 milligrams 1/2 tablets that belonged to C5 were unaccounted for except for two tablets left on the card.</p>	06385		
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06385	<p>Continued From page 7</p> <p>A document dated April 2, 2014 signed by RN-C indicated that on March 18, 2014, it was noted that C4 was missing one tablet of oxycodone 5 milligrams.</p> <p>A document dated April 2, 2014 signed by RN-C indicated that on March 24, 2014, it was noted that C6 was missing two tablets of oxycodone 5 milligrams.</p> <p>A document titled "Investigative Report" (undated) indicated that on January 19, 2014, C7 had the medication dilaudid (an opioid narcotic pain medication) delivered from the pharmacy. A week later, it was noted that C5 was short three days of the dilaudid.</p> <p>When interviewed April 25, 2014 at 10:10 a.m., RN-C stated that sometime in June or July of 2013, someone had replaced C2's vicodin (an opioid narcotic pain medication) with Tylenol. And in May or June of 2013, C3's physician discontinued C3's oxycodone. C3's oxycodone was stored in a narcotic drawer to be destroyed later, but then was missing.</p> <p>When interviewed April 15, 2014 at 9:50 a.m., Employee A/housing director stated that narcotic medications were counted when they were delivered by the pharmacy and then the medication was placed in a locked narcotic drawer in a locked medication cart. The narcotic medications were not counted again until a bubble pack card of medication needed to be replaced and put in the client's apartment medication storage area. In addition, narcotic medications that were discontinued for a client were stored in the narcotic drawer until the medication could be destroyed by the registered</p>	06385		

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06385	Continued From page 8 nurse. The narcotic medication that had been discontinued was not counted again until the medication was destroyed. The licensee did not have any written policies/procedures related to the control of narcotic medications in the facility. TIME PERIOD FOR CORRECTION: Thirty (30) days	06385		
06410	4668.0865 Subp. 8 Storage of Drugs Subp. 8. Storage of drugs. A class F home care provider licensee providing central storage of medications must store all drugs in locked compartments under proper temperature controls and permit only authorized nursing personnel to have access to keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to ensure that only authorized nursing personnel had access to keys where medications were stored for one of two medication storage areas observed. The findings included: On April 15, 204 at 1:15 p.m. observations revealed that Apartment 16, which was an empty client apartment, contained five cardboard boxes of medication bubble pack cards belonging to numerous clients. Some of the bubble pack cards	06410		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H24848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
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NAME OF PROVIDER OR SUPPLIER ELMHURST COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 400 3RD STREET SOUTHWEST BRAHAM, MN 55006
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06410	<p>Continued From page 9</p> <p>contained medications such as, Lasix (a diuretic medication), baclofen (an antispastic medication), citalopram (an antidepressant medication), lisinopril,(a blood pressure medication) potassium (a mineral supplement) and aspirin (a analgesic medication). Some of the bubble pack cards were empty. Although this apartment was locked, all staff, including housekeeping, maintenance, dietary and the housing director, had keys that opened the apartment.</p> <p>When interviewed, April 15, 2014 at 1:15 p.m., Employee A/housing director indicated that on Tuesdays, the pharmacy picked up the boxes and then on Wednesday delivered more boxes containing bubble pack medication cards, which were then distributed to the clients rooms on Saturdays. Apartment 16 was the storage area for the boxes of medication cards to be picked up and the medication cards to be dropped off. Employee A confirmed that staff, other than nursing staff also had keys to this apartment, and therefore had access to the apartment.</p> <p>Observations on April 15, 2014 at 10:30 a.m., revealed that narcotic medications were centrally stored in a locked drawer in a locked medication cart.</p> <p>When interviewed April 25, 2014 at 10:10 a.m., registered nurse (RN)-C indicated that the narcotic medications stored in the locked drawer were clients' narcotics that were surplus and were kept in this drawer until they needed to be replaced in the clients' apartments. RN-C stated that she was the only staff person that had a key to this drawer, although she kept the key in her purse, which was stored in a bin in an unlocked room that staff went in and out of throughout the day.</p>	06410		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H24848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
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NAME OF PROVIDER OR SUPPLIER ELMHURST COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 400 3RD STREET SOUTHWEST BRAHAM, MN 55006
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06410	<p>Continued From page 10</p> <p>A written statement which was undated indicated that on March 24, 2014 at 2:00 p.m., a staff person was observed to go into RN-C's purse in the office and took the narcotic key for the narcotic drawer out of RN-C's purse.</p> <p>The licensee's policy titled "Medication Storage" dated March 13, 2013 indicated the following: "Only authorized nursing personnel will have access to the keys (and med carts) for the central storage medication area. The medication area must be locked when nursing personnel are not present."</p> <p>TIME PERIOD FOR CORRECTION: Thirty (30) days</p>	06410		



Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up
PUBLIC DATA

Facility:

Elmhurst Commons
400 3rd Street Southwest
Braham, MN 55006
Isanti County

Report #: HL24848002

Date: July 3, 2014

Date of Visit: July 1, 2014
Time of Visit: 8:00 a.m. to 10:30 a.m.

By: Lisa Jacobsen, R.N.
Special Investigator

Nature of Visit

An unannounced visit was made in order to follow-up four state licensing order(s) which were issued on May 12, 2014, as the result of an investigation which had been completed on April 25, 2014.

The status of each order is as follows:

- 1 626.557 Subd.3 - Corrected
- 2 4668.0805 Subp. 1 - Corrected
- 3 4668.0865 Subp. 3 - Corrected
- 4 4668.0865 Subp. 8 - Corrected

xc: Minnesota Department of Health – Licensing and Certification

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number H24848	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/1/2014
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Name of Facility ELMHURST COMMONS	Street Address, City, State, Zip Code 400 3RD STREET SOUTHWEST BRAHAM, MN 55006
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>00605</u> Reg. # <u>626.557 Subd.3</u> LSC _____	Correction Completed <u>07/01/2014</u>	ID Prefix <u>06040</u> Reg. # <u>4668.0805 Subp. 1</u> LSC _____	Correction Completed <u>07/01/2014</u>	ID Prefix <u>06385</u> Reg. # <u>4668.0865 Subp. 3</u> LSC _____	Correction Completed <u>07/01/2014</u>
ID Prefix <u>06410</u> Reg. # <u>4668.0865 Subp. 8</u> LSC _____	Correction Completed <u>07/01/2014</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on: <u>4/25/2014</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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