Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Waterford Manor

Facility Address:
6288 Louisiana Court N.

Facility City:
Brooklyn Park

State:	ZIP:	County:
Minnesota	55428	Hennepin

Report Number:
HL29078012 and HL29078013

Date of Visit:
December 8 and 9, 2016

Time of Visit:
5:30 a.m. to 3:45 p.m.
8:00 a.m. to 4:15 a.m.

Date Concluded:
December 22, 2017

Investigator's Name and Title:
Deborah Neuberger, RN, Special Investigator
Kathleen Smith, DNP, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the staff found the resident wearing heavily saturated incontinence products. The resident had a severe buttocks wound covered with dead tissue. The facility transferred the resident to the hospital for wound treatment.

It is alleged that a client was neglected when the client was found by staff to be very wet with a necrotic wound on the client's bottom.

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

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

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect is substantiated. The home care provider failed to ensure wound care treatment was initiated in a timely manner, resulting in dead tissue covering the client's wound, and requiring hospitalization for wound care treatment.

The client received services from the comprehensive home care provider. The client's diagnoses included cognitive impairment, stress incontinence, hearing loss, and osteoarthritis. The client's services included toileting assistance every two hours and as needed. The client required the use of incontinence products.

The client was seen by the nurse practitioner in August, and it was documented the client had no skin rashes or lesions. Three weeks later, an order was received to apply medication to the buttock for rash and redness. There are no home care provider notes describing these rashes or redness. Two weeks later, the client's service plan was updated to include turning and repositioning of the client every two hours; however, the home care provider's assessment of the client indicated there are no wounds present. One week later, the client was seen by the nurse practitioner and found to have an open area on the buttocks, with bleeding, and a wound care consultation was ordered. The client's record indicated the home care

provider faxed the order to an outside home health agency on the same day it was received. Seven days later, the home care provider identified that wound care services had not been initiated and resent the order. There is no documentation by the home care provider noting any wound care, a description of the wound, or any follow up with the nurse practitioner.

Two days after receiving the order, the home health agency assessed the wound as having dark tissue and open areas, and this was reported to the physician, the home care provider, and the family. The physician ordered the client be sent to the hospital for a wound to the coccyx with possible infection. Additionally, the home health agency nurse noted the client to was wearing a double padded incontinence brief soiled with stool and urine.

Review of the medical record did not identify any communication between the home care provider staff, or from the home care provider staff to the physician, regarding the status of the wound. Direct care staff had documented the client required a pad to be used with the client's brief to make it fit, although during an interview, a nurse for the home care provider indicated this was not an appropriate action.

The client was hospitalized for six days and transferred to a long term care facility and received skilled wound care that could not be provided by the home care provider. The client's wound did not heal, and the client died.

Eight direct care staff were interviewed. Staff stated that if they note redness on a client's skin, they notify the nurse, and it should be documented. Two staff stated nurses were made aware of the wound to the client's buttocks, however no changes were noted in the communication book.

The home care provider terminated the employment of six direct care staff in relation to double-padding of incontinence products on clients.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The home care provider is responsible for the neglect because the home care provider failed to ensure staff followed their policies regarding orders implementation and skin assessment. The home care provider's policy indicated new orders should be implemented within 24 hours, but multiple staff failed to follow up to ensure the physician's order for wound care was implemented. The home care provider also had a policy which indicated staff would inspect the skin for redness, discoloration, and skin breakdown, but multiple

staff who were aware of the wound failed to document an assessment of the skin breakdown.

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 17 - Neglect

"Neglect" means:

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

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

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

Other pertinent medical records:

- [x] Other, specify:

Additional facility records:

- [x] Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seventeen

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

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

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ Call Light
☒ Infection Control
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Meals
☒ Facility Tour
☒ Incontinence

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A
Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Brooklyn Park Police Department

Hennepin County Attorney

Brooklyn Park City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 22, 2018

Mr. Rodolfo Parra, Administrator
Waterford Manor
6288 Louisiana Court North
Brooklyn Park, MN 55428

RE: Complaint Number HL29078012 and HL29078013

Dear Mr. Parra:

On February 5, 2018 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 November 3, 2017. At this time, these correction orders were found corrected. This is in relation to these orders only and does not impact any orders issued separately under complaints HL29078015, HL29078016, HL29078017, HL29078020 and HL29078021.

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

MLH

Enclosure

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29078	A. BUILDING: _____ B. WING _____	C 11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD MANOR	6288 LOUISIANA COURT NORTH BROOKLYN PARK, MN 55428

(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, these correction orders are 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 December 8, 2016, a complaint investigation was initiated to investigate complaints #HL29078012 and #HL29078013. At the time of the survey, there were 83 clients receiving services under the comprehensive license. The following correction orders are issued in relation to #HL29078012 and #HL29078013.	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/rules for Nursing Homes. 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 and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors, findings are 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/RULES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2).	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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0 315	Continued From page 1	0 315		
0 315 SS=H	144A.44, Subd. 1(12) Served by People Who Are Competent Subdivision 1. Statement of rights. A person who receives home care services has these rights: (12) the right to be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: #HL29078012 and #HL29078013 Based on interview and document review, the licensee failed to provide care and services by people who were trained and competent to perform their duties, for three of three clients reviewed. Client #1 (C1) had physician orders for a dressing change to the buttock, and these orders were not implemented for nine days, resulting in further skin breakdown requiring C1 to be hospitalized. Additionally, C1 was discovered wearing two protective briefs saturated with urine and dried stool on the skin surfaces. C2 was found wearing clothing and two protective briefs saturated with urine, and C3 was discovered wearing two protective briefs and clothing saturated in urine. 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:	0 315		

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0 315	Continued From page 2 C1 began receiving services on November 1, 2015, with diagnoses that included cognitive impairment, stress incontinence, hearing loss, and osteroarthritis. A review of the provider service notes dated August 17, 2016, indicated C1 had no rashes or lesions noted on the skin. A Physician Order dated September 11, 2016 for C1 stated medication was to be applied to redness on the buttocks. A provider service note for C1 dated September 26, 2016, noted an open area to the buttocks with scant bleeding, and ordered a wound care consultation. The order document notes the order was faxed to an outside homecare agency on September 26, 2016. According to a resident note for C1, dated October 3, 2016, the agency did not receive the wound care order. A review of the "VA Investigative Findings" document dated October 6, 2016, indicated the wound care request was refaxed on October 3, 2016. A review of the outside agency nurse visit note dated October 6, 2016, reveals the wound has dark tissue and open areas, this was reported to the physician, facility and family. A physician's order dated October 6, 2016 stated C1 was sent to the hospital for a wound to the coccyx with possible infection. A review of the "Service Plan" signed and dated September 9, 2016, indicated C1 was incontinent and required bathroom/toileting assistance every two hours and as needed. The "Quality of Life" document dated June 20, 2016 for C1 noted assistance was required for continence care and toileting. A document dated October 6, 2016, signed by an ULP, indicated C1 required a pad be used with the brief to make it fit better. Additionally, the document noted this practice was used for other clients. A review of Resident	0 315		

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0 315	Continued From page 3 Notes dated October 6, 2016, indicated communication was received that C1 was found in two saturated protective briefs with dried stool on her/his skin. A document dated October 7, 2016, and signed by an ULP, indicated C1 had one protective brief and maxi-pad on. Document review did not identify any documentation indicating the wound to the C1's buttocks was assessed by any staff of the home care provider. An interview with Licensed Practical Nurse (LPN-A), on December 9, 2016 at 3:05 p.m., indicated wound care services were provided by an outside agency. C1 had a skin problem to the buttock, without bleeding and about two centimeters in diameter. The outside wound care agency was contacted, the registered nurse came on a different shift, and C1 was sent to the hospital on another shift. An interview with Registered Nurse (RN-G), on December 27, 2016 at 2:35 p.m. indicated C1 had a urine saturated protective brief and sanitary pad. Additionally, C1 had a wound to the buttocks that was black in color. RN-G stated the unlicensed personnel (ULP) present was told double padding was inappropriate. An interview with Unlicensed Personnel (ULP-L), on December 29, 2016 at 12:09 p.m., indicated nursing was made aware C1 had a wound on the buttocks that was getting worse and had an odor, however, a nurse did not come to look at the skin. C2 had diagnoses that included dementia and depression. A review of the Service Plan signed and dated April 14, 2016 reveals C2 required	0 315		

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0 315	Continued From page 4 assistance with cleaning and changing incontinence products. A document titled "Quality of Life Assessment" and dated October 4, 2016 indicated C2 required full assistance and was incontinent of bowel and bladder. A document dated October 5, 2016 and signed by ULP-R, indicated C2 was discovered wearing two protective briefs that were saturated with urine along with her/his clothing. During an interview on December 12, 2016 at 2:22 p.m., ULP-F stated double padding was a common practice at the home care provider. C3 began receiving services March 19, 2013, with diagnoses that included short-term memory loss and hypertension. A review of the Service Plan dated and signed May 19, 2016, for C3 indicated full assistance was required for bladder and bowel care. The "Quality of Life Assessment" for C3 dated May 1, 2016 noted C3 was incontinent of bowel and bladder. A document dated October 5, 2016 and signed by ULP-R, indicated C3 was discovered with her/his clothing saturated in urine and wearing two protective briefs. The Employee Handbook dated June 2015 indicated under standards of conduct that termination of employment may result from neglect of a resident. The In-Services Training document stated annual training topics included the Bill of Rights. The home care provider's policy titled "Implementing Changes in Medication and Treatment Orders," stated changes in orders should be implemented within twenty-four (24) hours.	0 315		

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0 315	Continued From page 5 The home care provider's policy for skin care indicated staff are to inspect the skin for redness, discoloration, and skin breakdown. The home care provider's policy for nursing assessments of clients indicated a focused assessment should be completed for any area of concern. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 315		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (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: #HL29078012 and #HL29078013 Based on interview and document review, the licensee failed to ensure one of one client (C1) reviewed was free from maltreatment (neglect) when C1 was found wearing a protective brief and sanitary pad saturated with urine, and had a pressure sore on the buttocks which was not assessed or treated for nine days after a physician order for wound care was received. C1 required hospitalization for additional wound care. This practice resulted in a level three violation (a	0 325		

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0 325	Continued From page 6 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 isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 began receiving services on November 1, 2015, with a diagnosis that included cognitive impairment, stress incontinence, hearing loss, and osteroarthritis. A review of the provider service notes dated August 17, 2016, indicated C1 had no rashes or lesions noted on the skin. A Physician Order dated September 11, 2016 for C1 stated medication was to be applied to redness on the buttocks. A provider service note for C1 dated September 26, 2016, noted an open area to the buttocks with scant bleeding, and ordered a wound care consultation. The order document notes the order was faxed to an outside homecare agency on September 26, 2016. According to a resident note for C1, dated October 3, 2016, the agency did not receive the wound care order. A review of the "VA Investigative Findings" document dated October 6, 2016, indicated the wound care request was refaxed on October 3, 2016. A review of the outside agency nurse visit note dated October 6, 2016, reveals the wound has dark tissue and open areas, this was reported to the physician, facility and family. A physician's order dated October 6, 2016 stated C1 was sent to the hospital for a wound to the coccyx with possible infection. A review of the "Service Plan" signed and dated September 9, 2016, indicated C1 was incontinent and required bathroom/toileting assistance every	0 325		

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0 325	Continued From page 7 two hours and as needed. The "Quality of Life" document dated June 20, 2016 for C1 noted assistance was required for continence care and toileting. A document dated October 6, 2016, signed by an ULP, indicated C1 required a pad be used with the brief to make it fit better. Additionally, the document noted this practice was used for other clients. A review of Resident Notes dated October 6, 2016, indicated communication was received that C1 was found in two saturated protective briefs with dried stool on her/his skin. A document dated October 7, 2016, and signed by an ULP, indicated C1 had one protective brief and maxi-pad on. Document review did not identify any documentation indicating the wound to the C1's buttocks was assessed by any staff of the home care provider. An interview with Licensed Practical Nurse (LPN-A), on December 9, 2016 at 3:05 p.m., indicated wound care services were provided by an outside agency. C1 had a skin problem to the buttock, without bleeding and about two centimeters in diameter. The outside wound care agency was contacted, the registered nurse came on a different shift, and C1 was sent to the hospital on another shift. An interview with Registered Nurse (RN-G), on December 27, 2016 at 2:35 p.m. indicated C1 had a urine saturated protective brief and sanitary pad. Additionally, C1 had a wound to the buttocks that was black in color. RN-G stated the unlicensed personnel (ULP) present was told double padding was inappropriate. An interview with Unlicensed Personnel (ULP-L), on December 29, 2016 at 12:09 p.m., indicated	0 325		

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	H29078	A. BUILDING: _____ B. WING _____	C 11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD MANOR	6288 LOUISIANA COURT NORTH BROOKLYN PARK, MN 55428

(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
0 325	Continued From page 8 nursing was made aware C1 had a wound on the buttocks that was getting worse and had an odor, however, a nurse did not come to look at the skin. The Employee Handbook dated June 2015 indicated under standards of conduct that termination of employment may result from neglect of a resident. The In-Services Training document stated annual training topics included the Bill of Rights. The home care provider's policy titled "Implementing Changes in Medication and Treatment Orders," stated changes in orders should be implemented within twenty-four (24) hours. The home care provider's policy for skin care indicated staff are to inspect the skin for redness, discoloration, and skin breakdown. The home care provider's policy for nursing assessments of clients indicated a focused assessment should be completed for any area of concern. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8433

November 21, 2017

Mr. Rodolfo Parra, Administrator
Waterford Manor
6288 Louisiana Court North
Brooklyn Park, MN 55428

RE: Complaint Number HL29078012 and HL29078013

Dear Mr. Parra :

A complaint investigation (#HL29078012 and HL29078013) of the Home Care Provider named above was completed on November 3, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

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

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

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

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

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

Sincerely,

Matthew Heffron

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

MLH

Enclosure

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