DEPARTMENT OF HEALTH

# Office of Health Facility Complaints Investigative Report
PUBLIC

**Facility Name:**
Lino Lakes GW LLC

**Facility Address:**
675 Market Place Drive

**Facility City:**
Lino Lakes

**State:** Minnesota | **ZIP:** 55014 | **County:** Anoka

**Report Number:**
HL31673001, HL31673002, HL31673003

**Date of Visit:**
July 21, 2017

**Time of Visit:**
9:30 a.m. to 2:30 p.m.

**Date Concluded:**
January 17, 2018

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

☒ **Home Care Provider/Assisted Living**

## Allegation(s):

It is alleged that a client was neglected when a staff/alleged perpetrator (AP) failed to provide adequate supervision to the client. The AP, who worked overnight, did not see the client in the room and did not attempt to locate him/her. The next day, cleaning staff found client in the closet on the floor. Client was covered in feces and urine and had a large bruise on the buttock and right shoulder. Client was taken to the hospital.

☒ 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 occurred when staff were unaware of the clients whereabouts for 12.5 hours. The client was found on the floor of his/her room covered with feces and urine and had bruises to buttocks and shoulder. The client was found when staff went in to clean the room, 12.5 hours after s/he was last seen by staff. The client was lethargic and confused greater than baseline. The client was sent to the hospital via ambulance for assessment.

The client received services from the comprehensive home-care provider that included assistance with toileting, bathing, dressing, grooming, escorts, medication management, and safety checks every two hours according to a service agreement. The client had a diagnosis of dementia.

When there is a change of shift it was protocol for on-coming and off-going staff to do rounds together, as the previous shift reports off to the next shift. This did not happen on the night of the incident. The staff went to the client's room to provide a scheduled safety check. The client was not in the room or bathroom,

and the client's bed was still made appearing as though s/he had not slept in it.

There was no verbal nor written report information provided by the previous shift to indicate the client was out of the building. There is a log kept at the entrance of the building for clients to sign out when they leave the building. Staff admitted they did not refer to this log. Staff also stated they entered every room for work-related tasks with the exception of the room directly across from the client's room.

No further checks were made to the client's room after the staff concluded the client was not in the building. The staff also passed on to the next shift that the client was out of the building and therefor no checks were made on that shift. Four hours into the shift the staff went to provide housekeeping services to the client and found him/her on the floor, undergarment pulled off and lying in feces and urine.

The nurse on call was called an hour after finding the client due to lethargy and increased confusion. The client was then sent to the hospital via ambulance. Client was admitted to the hospital for three days.

Staff admitted they incorrectly concluded the client was out of the building with family overnight. One staff member said, "Many mistakes were made." Staff were able to accurately report the proper and expected response to a missing client and stated, "we didn't do it".

When the client was interviewed six weeks after the incident, s/he stated s/he still has a stiff arm and a stiff back.

Family stated they were first made aware of the fall when police who responded to the 911 call called to inform them about their response to the call.

The home-care provider responded immediately with re-training of staff to all relevant policies and procedures.

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 had policies and procedures in place to prevent neglect from occurring, however, multiple staff members did not follow these procedures.

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 Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

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 Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

**Compliance Notes:**

## Definitions:

**Minnesota Statutes, section 626.5572, subdivision 17 - Neglect**

"Neglect" means:

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

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; 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] Care Guide
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

**Other pertinent medical records:**

- [x] Hospital Records
- [x] Police Report

**Additional facility records:**

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] 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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

| Date: | Time: | Date: | Time: | Date: | Time: |
|---|---|---|---|---|---|
| | | | | | |

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

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

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

**Tennessen Warnings**

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

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:**

- ☒ Personal Care
- ☒ Nursing Services
- ☒ Call Light
- ☒ Infection Control
- ☒ Cleanliness
- ☒ Dignity/Privacy Issues
- ☒ Safety Issues
- ☒ Transfers
- ☒ Meals
- ☒ Facility Tour

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**

**Lino Lakes Police Department**

**Anoka County Attorney**

**Lino Lakes City Attorney**

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H31673 | A. BUILDING: _____ B. WING _____ | C 08/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINO LAKES GW LLC | 675 MARKET PLACE DRIVE LINO LAKES, MN 55014 |

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| 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, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On July 21, 2017, a complaint investigation was initiated to investigate complaint #HL31673001, HL31673002, and HL31673003 . At the time of the survey, there were 27 clients that were receiving services under the comprehensive license. The following correction orders are issued. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br><br>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 Suggested Method of Correction and the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 0 325 SS=G | 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: | 0 325 | | |

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| 0 325 | Continued From page 1<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on document review, observation, and interview, the licensee failed to ensure that one of one clients (C1) reviewed was free from neglect when the staff was unaware of C1's whereabouts for 12.5 hours. The client was found on the floor of her room covered with feces and urine. C1 was lethargic and confused greater than her baseline, was sent to the hospital via ambulance for assessment, and was admitted to the hospital for three days.<br><br>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 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>The findings include:<br><br>C1's record was reviewed. The client received services from a provider licensed as a comprehensive homecare provider. C1 received assistance with toileting, bathing, dressing, grooming, escorts, medication management, and safety checks every two hours according to a service agreement dated January 19, 2017. C1's diagnoses included dementia. | 0 325 | | |

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| 0 325 | Continued From page 2<br><br>Document review of a form titled, "Vulnerability Assessment and Prevention Plan" dated January 19, 2017 indicated C1 was vulnerable for orientation to time/place/person intermittently and required staff re-direction and every two hour safety checks. A nursing assessment dated June 1, 2017 indicated C1 was forgetful with short term memory loss and has a history of falls. The assessment also indicated C1 could use the pendant/call light system appropriately.<br><br>Document review of a form titled, "24 Hour Resident Summary" was used by the unlicensed personnel (ULP) staff as a communication tool between shifts on June 2, 2017 and June 3, 2017. On June 2, 2017 the day shift (6:30 a.m. to 2:30 p.m.) documented on the form that C1's room was cleaned and vacuumed. There was nothing documented by the evening shift (2:30 p.m. to 10:30 p.m.). The night shift (starting on June 2, 2017 going into June 3, 2017) was responsible to start a new sheet dated June 3, 2017. The night shift documented "LOA" on the June 3, 2017 form for C1. The format of the 24 hour form begins with the night shift, then day shift, and ends with the evening shift.<br><br>Document review of an untitled form where ULPs recorded cares dated June 2, 2017 indicated the evening ULPs documented an oxygen saturation (percentage of oxygenation to the blood) check on C1 at 4:00 p.m. and 8:00 p.m.; and a "last check" on C1 at 10:03 p.m. A new form was started by the night shift for the next calendar day dated June 3, 2017.<br><br>Document review of an untitled form where ULPs recorded cares dated June 3, 2017 indicated ULP-F wrote "LOA" for C1 in the "last check" column for night shift. | 0 325 | | |

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| 0 325 | Continued From page 3<br><br>An incident report dated June 3, 2017 at 10:30 a.m. indicated the day shift ULPs were told by the night shift ULPs that C1 was LOA and "According to noc (night) shift, ULP-F, said they're glad they went to check in their [sic] otherwise they wouldn't have known she was gone." Report also indicated ULP went in to clean C1's room and found her on the floor near her fish tank and closet, her brief pulled down, with "body fluid" on the floor.<br><br>Document review of a form titled "Resident Sign Out Sheet" consisted of the first line entry dated May 31st. The last line was dated June 4th. There were 11 entries; none were C1's name.<br><br>During an unannounced on-site visit on July 21, 2017 at 9:30 a.m. C1's room was viewed. There is a direct line of sight into the entire room from the doorway. The layout of the floor plan is predominantly a rectangle with short extensions at the corners. C1's room is located at the end of one of the extensions, out of the main line of sight down the longer hallway. C1's room has a pull cord located on the wall next to her bed. Pull cord does not reach to the floor where it was indicated C1 was found.<br><br>Interviewed C1 on July 21, 2017 at 1:41 p.m. who stated she does remember that incident and stated, "I still have a stiff arm and a stiff back." When asked how she calls for help, she said, "I have good friends."<br><br>Interviewed ULP-F on August 2, 2017 at 10:55 a.m. who stated she was one of two ULPs that worked the night shift of June 2, 2017 into June 3, 2017. She stated the typical routine is to "do rounds" with the off-going staff. This was | 0 325 | | |

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| 0 325 | Continued From page 4 | 0 325 | | |

described as going door to door to check on each resident with one ULP from the on-coming shift and one from the off-going shift. On the night of June 2, 2017 the ULP stated the previous shift was in a hurry to leave and chose not to do rounds with the night shift ULP. She also said the previous shift should inform the next one of any clients who are out of the building or on leave of absence (LOA).

ULP-F said when she went to check C1 for the scheduled safety check C1 was not in the room; furthermore, her bed was still made appearing as though it had not been slept in. ULP-F asked ULP-C to also check the room. The conclusion was made that the evening shift failed to inform them C1 was on LOA. ULP-F then documented that C1 was LOA.

ULP-F stated there was nothing said orally at shift change, nor written on the 24 hour report sheet to indicate C1 was on LOA. She also admitted she did not view the client sign out log. She stated all the vacant rooms in the building were checked. She stated she did not call the on-call nurse to inquire about the absence of C1 nor to report her as missing.

During an interview on August 2, 2017 at 11:46 a.m., ULP-C stated she was one of two ULPs that worked the night shift of June 2, 2017 into June 3, 2017. She stated rounds were not done because ULP-E "didn't want to do it."

ULP-C said she checked client rooms and found a client's room and bathroom empty with the normally turned on night-light off. ULP-C said no verbal report was received about this client being on LOA. When approached by ULP-F about C1 not in her room, the ULPs concluded both clients

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| 0 325 | Continued From page 5<br>were on LOA. ULP-C stated however, she went to C1s room to confirm her absence. She said she went into the room, turned on the light, the bed was made, and she checked in the bathroom; C1 was not in the room.<br><br>ULP-C said due to the cleaning schedule every unoccupied room was entered. She also said the clients' rooms were all entered due to services provided clients with the exception of the room directly across the hall from C1.<br><br>ULP-C admitted she did not view the client sign out log. She said too there was no verbal report given that indicated C1 was on LOA. ULP-C further stated "mistakes were made" and stated no calls were placed to the nurse or the manager and there should have been.<br><br>Interviewed registered nurse (RN)-B on August 2, 2017 at 10:20 a.m. who stated she was the nurse on-call June 2, 2017 and June 3, 2017. She stated the first call she received from the ULP in regards to C1 was at 11:50 a.m. on June 3, 2017; she denied receiving any calls the night before about C1 not found in her room.<br><br>Interviewed director of nursing RN-A on July 21, 2017 at 1:14 p.m. who stated C1 returned from the hospital with no serious injuries. No changes were made to the service plan.<br><br>Document review of a policy titled, "Missing Client" dated November 14, 2016 provided direction on how to respond when a client "is not where the client can reasonably be expected to be" by promptly implementing the following: "a. Determine if the client is away...by checking with other staff, checking the communication log, sign in/sign out sheet...b. If the client is not...prompt | 0 325 | | |

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| 0 325 | Continued From page 6<br>and thorough search...entire building. c. If the client is not located: Notify the RN..."<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 325 | | |
| 01225 SS=E | 144A.4797, Subd. 3 Supervision of Staff - Comp<br><br>Subd. 3. Supervision of staff providing delegated nursing or therapy home care tasks. (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and<br>must include observation of the staff administering the medication or treatment and the interaction with<br>the client.<br><br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after<br>the individual begins working for the home care provider and thereafter as needed based on performance.<br>This requirement also applies to staff who have not performed delegated tasks for one year or longer. | 01225 | | |

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| 01225 | Continued From page 7<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) provided supervision of staff performing delegated tasks within 30 days after hire for two of three unlicensed personnel (ULP) files reviewed.<br><br>The violation occurred as a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive).<br><br>The findings include:<br><br>Document review of ULP-E employee file indicated she was hired on January 30, 2016. There was no 30 day performance evaluation documented in the employee file; first review was dated April 30, 2016.<br><br>Document review of ULP-C employee file indicated she was hired on July 5, 2016. There was no 30 day performance evaluation documented in the employee file; first review was dated October 10, 2016.<br><br>Interviewed director of nursing, registered nurse (RN)-A who stated she has been employed for five months; ULP-C and ULP-E were hired prior to her start date. | 01225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H31673 | A. BUILDING: _____ B. WING _____ | C 08/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINO LAKES GW LLC | 675 MARKET PLACE DRIVE LINO LAKES, MN 55014 |

| (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 |
|---|---|---|---|---|
| 01225 | Continued From page 8<br>A policy titled "Supervision of Licensed and Unlicensed Personnel" dated October 30, 2015 and reviewed November 14, 2016 indicated direct supervision of the ULP must be done within 30 days of beginning work for the homecare provider.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01225 | | |

DEPARTMENT OF HEALTH

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

Certified Mail Number: 7015 3010 0001 4648 6255

January 17, 2018

Administrator
Lino Lakes GW LLC
675 Market Place Drive
Lino Lakes, MN 55014

RE: Complaint Number HL31673001, HL31673002, and HL31673003

Dear Administrator:

A complaint investigation (#HL31673001, HL31673002, and HL31673003) of the Home Care Provider named above was completed on August 4, 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
Anoka County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services