DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Birchwood Cottages		**Report Number:** HL31944002 - HL31944003	**Date of Visit:** November 9, 2017
Facility Address: 1905 Austin Road		**Time of Visit:** 8:30 a.m. to 2:45 p.m.	**Date Concluded:** March 12, 2018
Facility City: Owatonna		**Investigator's Name and Title:** Earl F Bakke, RN, Special Investigator	
State: Minnesota	**ZIP:** 55060	**County:** Steele	

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was abused when the alleged perpetrator grabbed the client by the wrist and shoved him/her backwards. It is also alleged that the perpetrator spoke to the client in a threatening manner.

☒ 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 the preponderance of evidence, the allegation of physical and verbal abuse is substantiated. The alleged perpetrator (AP) was yelling at the client while at the same time the AP grabbed the client's wrist and shoved him/her backward.

The client received services from the comprehensive home care provider for medication administration, toileting, safety checks, and transfers/ambulation/mobility assistance. The client does have a medical condition that limits his/her cognitive and communication ability.

A staff member and the AP were in the client's room. The staff member and the AP had guided the client to the bathroom and positioned him/her at the front of the toilet. The client began to sit down on the toilet, and the AP began to lower his/her pants and incontinence briefs. The client tried to stand up. The staff member told the AP to let the client stand up and that they would try to toilet the client again later. The AP continued to lower the client's clothing saying, "no that this needed to be done now". The client pushed the AP, and he/she fell backward onto his/her hands. The client stood up and began to walk out of the bathroom. The AP got up, walked over to the front of the client and grabbed his/her wrist. The AP began to yell at the client and shoved him/her backward.

During an interview with a staff member, he/she said the client had sat on the toilet, and the AP and him/her were assisting with lowering pants and undergarments. Suddenly, the client began to stand up and try to walk out. The AP blocked the client and continued to try and lower the pants and undergarments. The AP told the staff member that the client needed to use the bathroom now and they were going to get this done. The AP continued to lowering the clothing at the same time as the client was trying to stand. The client pushed the AP backward causing him/her to fall onto his/her hands. The client walked out of the bathroom, and the AP got up and followed. The AP stepped in front of the client, grabbed his wrist, and began shoving him/her backward and yelling at him/her. The staff member yelled at the AP to stop, but the AP continue to hold on to the client's wrist and kept shoving and yelling at him/her. The staff member feared for the safety of the client and ran out of the room to get another staff member.

During an interview with management, he/she said a staff member called after witnessing an event between the client and the AP. Based on the facts described by the staff member, management interviewed the AP. The AP told management that she/he had grabbed the client's wrist and was yelling. The AP said he/she had become frustrated and was going through some personal manners at home which were causing a lot of stress. Management said the AP's employment's terminated based on the events described above. Management said when he/she informed the AP of the termination, the AP started crying but said she understood the need to terminate the employment.

During an interview with the AP, he/she said that the client had become combative and grabbed his/her wrist and began twisting. The client had swung his/her arms and nearly knocked his/her glasses off. The AP said the client had a butter knife in his possession but did not describe what the client did with the knife and the knife is not mentioned in the AP's written statement to management. The AP denied grabbing the client's wrist, shoving him/her, or yelling in a threatening manner. The AP said he/she was not sure of the exact reason for termination.

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 AP had a background check that showed cleared to work. The AP received copies of an employee handbook that included the client's bill of rights, and training on the Vulnerable Adult Abuse Act. The AP nonetheless tried to force the client to comply with toileting and abused the client.

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:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

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

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

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

Other pertinent medical records:

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: Client had been transfered to specialty healthcare facility

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: Client not at facility and has no communicative ability

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Four

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:

- [x] Personal Care
- [x] Nursing Services
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Facility Tour
- [x] Injury

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 - Licensing & Certification

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Owatonna Police Department

Steele County Attorney

Owatonna City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: _____ B. WING _____	C 12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On November 9, 2017, a complaint investigation was initiated to investigate complaint #HL31944002 and HL31944003 . At the time of the survey, there were 58 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	
0 325 SS=D	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: _____ B. WING _____	C 12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(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 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the right of one of one client (C1) reviewed to be free from maltreatment of physical and verbal abuse when a staff member yelled at C1 in an aggressive manner while at the same time grabbing C1's wrist and shoving him backwards. 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 is issued at an isolated scope (when one or a very limited number of residents are affected and/or one of a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations). The findings include: C1's medical record was reviewed. C1's service agreement, dated May 18, 2017, indicated C1 received services for medication administration, toileting, safety checks, and assistance with transfers and ambulation. C1's cognitive ability was limited due existing medical conditions. A document titled, "Report of Suspected Maltreatment", dated September 15, 2017, indicated a resident aide (RA)-D had grabbed and	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: _____ B. WING _____	C 12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(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 2 pushed while at the same time telling C1 RA-D would sue him and asking if he wanted to go toe to toe. The document further indicated RA-D admitted to pushing C1 because C1 had RA-D's wrist. The document indicated RA-D did not recall the comments but that she could have made the statements. RA-D was terminated as a result of this incident. A handwritten document, untitled, dated September 15, 2017, indicated RA-(B) and RA-D were working with C1 for toileting. C1 had begun to pull on his pants and say no. RA-B told RA-D to leave C1 be and they would try again later. RA-D told RA-B no, that C1 could not leave with his pants down. RA-D continued to try and change C1. C1 pushed RA-D away. RA-D yelled at C1, "...you want to go toe to toe...." while and at the same time grabbed C1 by the wrist and started shoving C1 backwards. RA-B had left the room to get additional staff members. During an interview with the Campus Director (A), on November 9, 2017 at 12:26 p.m., the Campus Director said staff called her about an incident between RA-D and C1. The Campus director (A) met with several staff members and took statements and determined that RA-D had verbally and physically abused C1. The campus director (A) terminated RA-D's employment as a result of the allegation of physical and verbal abuse. During an interview with RA-B, on December 5, 2017 at 1:05 p.m., she said RA-D and her had attempted to toilet C1. C1 began to resist, stood up and tried to pulls his pants up. RA-D continued to try and remove C1's pants and undergarments. C1 pushed RA-D and walled out of the bathroom. RA-B said she witnessed RA-D	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: _____ B. WING _____	C 12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(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 3 walked over to C1, begin to yell at him and grab him by the wrist. RA-D had started shoving C1 backwards. RA-B said RA-D would not stop. RA-B screamed at RA-D to stop, but the grabbing by the wrist and shoving continued. RA-B ran out of the room to get additional staff for assistance. RA-B said she "definitely" felt the the actions of RA-D were physical and verbal abuse. During an interview with RA-D, on December 19, 2018 at 8:03 a.m., she said that C1 had become combative and struck her in the head, almost knocking her glasses off. C1 had grabbed her right arm and begun twisting it. RA-D denied grabbing C1's wrist or yelling. RA-D said she was trying to button C1's pants and that was when C1 became combative. A policy titled, "Vulnerable Adult (and Children or minors) Reporting Minnesota Adult Abuse Reporting Center and Investigation Policy", undated, indicated staff will be trained on the Vulnerable Adult Act and the licensee's report policy. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 325		
01185 SS=D	144A.4796, Subd. 5 Alzheimer's/Dementia Training Required Subd. 5. Training required relating to Alzheimer's disease and related disorders. For home care providers that provide services for persons with Alzheimer's or related disorders, all direct care staff and supervisors working with those clients must receive training that includes a current explanation of	01185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: _____ B. WING _____	C 12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(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
01185	Continued From page 4 Alzheimer's disease and related disorders, effective approaches to use to problem-solve when working with a client's challenging behaviors, and how to communicate with clients who have Alzheimer's or related disorders. This MN Requirement is not met as evidenced by: Based on document review, the licensee failed to provide dementia training to one of three employees, employee-D, reviewed which may have prevented a physical and verbal abuse incident that took place between the employee and a client who has cognitive limitations due to a medical condition. 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 is issued at an isolated scope (when one or a very limited number of residents are affected and/or one of a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations). The findings include: Employee-D's employee file was reviewed. The file contained a document titled, "Prairie Senior Cottages Dementia Training". The document had two pages and each page had employee-D's name written on the top. The document had a section titled dementia training checklist and an area to sign off as completed with a date and time. None of the sections were signed off as	01185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31944	A. BUILDING: _____ B. WING _____	C 12/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD COTTAGES	1905 AUSTIN ROAD OWATONNA, MN 55060

(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
01185	Continued From page 5 completed. The second page of the document did not have an employee signature, a mentor signature or a director's signature to indicate the training had been completed. During an interview with the Campus Director (A), on November 6, 2017 at 12:26 p.m. the Campus Director said she was not aware the form had not been completed and that all employees have to attend the training. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01185		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 70150640000458709961

March 12, 2018

Ms. Jessie Kellstadt, Administrator
Birchwood Cottages
1905 Austin Road
Owatonna, MN 55060

RE: Complaint Number HL31944002 & HL31944003

Dear Ms. Kellstadt:

A complaint investigation (#HL31944002 & HL31944003) of the Home Care Provider named above was completed on December 20, 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,

Mike Kaehler
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) 201-4181 Fax: (651) 281-9796

MK

Enclosure

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