Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL32424001M
Compliance #: HL32424002C

Date Concluded: February 24, 2020

Name, Address, and County of Licensee Investigated:

Butterfly Bound Care
5701 Shingle Creek Parkway
Suite 318D
Brooklyn Center, MN 55430
Hennepin County

Name, Address, and County of Housing with Services location:

Butterfly Bound Care
6207 Chowen Avenue North
Minneapolis, MN 55429
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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

Allegation(s):
It is alleged: The alleged perpetrator (AP) abused a client when he had sex with the client, gave the client $100, and then told the client that she would get kicked out if she told anyone.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility and the AP were responsible for the maltreatment. The facility failed to ensure that the AP completed training on staff/client boundaries. The AP told the client that if she had sex with him, he would make sure that she was not kicked out of the home. The AP gave the client $100 and then told her that if she told anyone about the incident she would be kicked out of the home.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator spoke with law enforcement. The investigator toured the facility, spoke with other clients living there, reviewed the client's records, reviewed the AP's personnel file, and reviewed the licensee's policies and training related to the Vulnerable Adult Act and appropriate boundaries.

The client moved in to the facility due to diagnoses that included mood swings, hepatitis, and hypothyroidism. The client was homeless at the time of admission. The client received services from the home care provider that included medication administration, meals, and assistance with appointments. The client had a private room on the lower level of the facility, where no other clients lived. The facility typically had one staff working at a time. The licensee and a nurse would come to the facility during the day.

The client received a notice from the licensee several weeks before the incident. The notice indicated the facility could no longer meet the client's needs due to the client's verbal outbursts. The client had 30 days to find a new living situation.

On the evening of the incident, the AP gave the client a back massage. The AP then asked the client to have sex with him. The AP told the client he would give her $100 for sex. The AP took the client in his car to the bank and to Walgreens. The AP left the other clients alone at the facility.

The AP brought the client back to the facility where they engaged in sex. Afterward, the AP told the client not to tell anyone or he would make sure she was kicked out of the facility. The client moved out of the facility about two weeks later.

During an interview, the client said she reported the incident to a county worker, who contacted police. The client said the police interviewed her. The client also expressed concern over the quality of care that the clients received at the facility.

During an interview, the owner said that the AP received some training prior to working with clients, but the owner did not ensure that the AP completed the online training modules that were required. Appropriate boundaries between staff and clients training was an online module that the AP was supposed to complete independently.

The AP did not show up for a scheduled interview.

The police report indicated that the case was ongoing.

In conclusion, abuse was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, at the request of the vulnerable adult
Alleged Perpetrator interviewed: No, the AP did not respond to a subpoena

Action taken by facility:
The AP is no longer employed by the facility. The facility provided retraining to all staff on staff/client boundaries.

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

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

cc: The Office of Ombudsman for Long-Term Care
Brooklyn Center Police Department
Brooklyn Center City Attorney's Office
Hennepin County Attorney's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32424	A. BUILDING: _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	**5701 SHINGLE CREEK PARKWAY SUITE 318D BROOKLYN CENTER, MN 55430**

(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, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 29, 2020 the Minnesota Department of Health initiated an investigation of complaint #HL32424002C/HL32424001M. At the time of the survey, there were three clients receiving services under the comprehensive license. The following correction orders are issued. The following correction orders are issued that were not issued at the time of immediate correction orders. The following correction order is issued/orders are issued for #HL32424002C/HL32424001M, tag identification 0805, 0815, 0870, 0875, 1065, 1225, and 2015	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	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		

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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 interviews, and document review, the facility failed to ensure one of one clients (C1) reviewed was free from maltreatment. C1 was abused. Findings include: On February 24, 2020, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the facility and an individual staff person was responsible for the maltreatment, in connection with incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6. Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected	0 805		

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0 805	Continued From page 2 maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report all suspected allegations of maltreatment to the State Agency for one of one clients (C1) reviewed. Police informed owner (O)-B of an allegation that unlicensed personnel (ULP)-C had sex with C1. O-B failed to make a report to the state agency. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1 moved into the facility on August 8, 2019 due to diagnoses that included mood swings, chronic hepatitis, hypothyroidism, and opioid dependency. C1's service plan dated August 9, 2019 indicated C1 received 24 customized care (services not specified). A police report dated September 24, 2019 indicated police went to the facility at 11:45 p.m. to follow up on a report that unlicensed personnel (ULP)-C had sex with C1 on September 20, 2019 between 9:30 p.m. and 10:00 p.m., gave C1 money afterward, and told C1 not to tell or C1 would get kicked out of the facility. The report	0 805		

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0 805	Continued From page 3 indicated an officer spoke to owner (O)-B about the allegation and gathered information from O-B. During an interview on January 29, 2020 at 2:57 p.m. O-B stated she did not report the allegation to the state agency, but knows that she should have. During an interview on January 30, 2020 at 12:37 p.m., registered nurse (RN)-D stated O-B informed her of the allegation but did not report to the state agency because she did not know that she was supposed to report. The Vulnerable Adult policy (undated) indicated all staff are mandated to report maltreatment immediately to the supervisor or the Minnesota Abuse Reporting Center (MAARC) to ensure that all suspected cases of adult maltreatment are reported under the statutes and to protect those who are vulnerable to abuse or neglect. TIME PERIOD FOR CORRECTION: SEVEN (7) days	0 805		
0 815 SS=D	144A.479, Subd. 7 Employee Records Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration,	0 815		

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0 815	Continued From page 4 or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure one of one unlicensed personnel (ULP)-C records reviewed contained a	0 815		

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0 815	Continued From page 5 current job description or background study in the personnel file. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The licensee hired ULP-C on March 22, 2019 to provide direct care and delegated nursing tasks. ULP-C's time cards indicated ULP-C worked the following dates and times: April 5, 2019 4:00 p.m. to 10:36 p.m., April 6, 2019 8:00 a.m. to 4:00 p.m., April 7, 2019 10:30 a.m. to 4:00 p.m., April 12, 2019 4:00 p.m. to 10:00 p.m., April 13, 2019 8:00 a.m. to 3:20 p.m., April 19, 2019 3:50 p.m. to 10:00 p.m., April 20, 2019 8:00 a.m. to 4:00 p.m., April 21, 2019 8:00 a.m. to 4:00 p.m., April 26, 2019 3:55 p.m. to 10:10 p.m., May 3, 2019 3:50 p.m. to 10:30 p.m., May 5, 2019 4:00 p.m. to 8:10 p.m., May 10, 2019 2:30 p.m. to 10:00 p.m., May 11, 2019 4:00 p.m. to 10:00 p.m., May 17, 2019 4:00 p.m. to 10:00 p.m., May 18, 2019 8:00 a.m. to 4:00 p.m., May 19, 2019 9:00 a.m. to 4:00 p.m., May 24, 2019 4:00 p.m. to 10:00 p.m., May 25, 2019 4:00 p.m. to 10:00 p.m., May 26, 2019 4:00 p.m. to 10:00 p.m., August 17, 2019 8:00 a.m. to 4:00 p.m., August 18, 2019 8:00 a.m. to 4:40 p.m., September 1, 2019 8:00 a.m. to 4:00 p.m., September 7, 2019 4:00 p.m. to 12:00 a.m., September 8, 2019 3:00 p.m. to 12:00 a.m., and Friday (undated, but reported by owner (O)-B to be September 20, 2019) 5:00 p.m. to 12:20 a.m.	0 815		

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0 815	Continued From page 6 ULP-C's personnel file lacked evidence of a job description and background study clearance. During an interview on January 29, 2020 at 2:57 p.m., owner (O)-B confirmed that ULP-C's personnel file did not contain a job description or background study clearance, but confirmed that the background study had been completed. O-B provided copy of ULP-C's background study clearance on January 30, 2020 at 5:41 p.m. dated March 28, 2019. The Background Studies policy (undated) indicated the licensee required background screening completed on all final candidates for employment. The policy indicated the licensee retain the results of the background studies in the confidential employee file. The Job Description policy (undated) indicated a description of each job shall be written using information obtained from job analysis, emphasizing the essentials of the job, with minimum qualifications of the job, signed by the employee, and placed in their personnel file. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 815		
0 870 SS=D	144A.4791, Subd. 9(f) Content of Service Plan (f) The service plan must include: (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;	0 870		

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0 870	Continued From page 7 (2) the identification of the staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring reviews or assessments of the client; (4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and (5) a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) information and a method for a client or client's representative to contact the home care provider; (iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure the contents of the service plans for four of four clients (C1, C2, C3, and C4) reviewed contained required elements. C1's, C3's and C4's service plans failed to include	0 870		

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0 870	Continued From page 8 the description of the services to be provided, the fees for services, the frequency of services, the identification of staff or category of staff to provide the services, the schedule and methods of monitoring reviews or assessments of the client, the frequency of supervision of staff and type of personnel who will supervise staff. C2's service plan failed to include the fee for services, the schedule and methods of monitoring reviews or assessments of the client, the frequency of sessions of supervision of staff and type of personnel who will supervise staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause 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). Findings include: C1's record was reviewed. C1 moved into the facility on August 8, 2019 due to diagnoses that included mood swings, chronic hepatitis, hypothyroidism, and opioid dependency. C1's service plan dated August 9, 2019 indicated C1 received 24 hour customized care (services not specified) from the home care provider. C2's record was reviewed. C2 moved into the facility on March 20, 2019 due to diagnoses that included stroke with hemiparesis, type two diabetes, hypertension, and obstructive sleep apnea. C2's service plan dated March 20, 2019 indicated C2 received service from the home care provider that included meal preparation,	0 870		

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0 870	Continued From page 9 assistance with activities of daily living, toileting, transfers, blood glucose monitoring, medication administration, nail care, and wound care. C3's record was reviewed. C3 moved into the facility on October 9, 2019 due to diagnoses that included stroke with slurred speech and changes to cognition, diabetes, chronic kidney disease, and depression. C3's service plan dated October 9, 2019 indicated C3 received 24 hour customized care (services not specified) from the home care provider. C4's record was reviewed. C4 moved into the facility on March 20, 2019 due to diagnoses that included end stage renal disease with dialysis, hypertension, anemia, and chronic pain. C4's service plan dated March 20, 2019 indicated C4 received 24 hour customized care from the home care provider that included assistance with activities of daily living, meals, mediation, monitoring, activities, assistance with transfers, and grooming. During an interview on February 3, 2020 at 9:20 a.m., owner (O)-B stated that the service plans for all four clients currently living in the facility were lacking the required contents. The Service Plan policy (undated) indicated that the service plan would include the following: a. A description of the home care services to be provided. b. The staff or categories of staff that will provide the services. c. The type and frequency of visits/services proposed to be furnished according to the client's current review/assessment and client preferences. d. The fees for services.	0 870		

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0 870	Continued From page 10 e. The schedule and methods of monitoring reviews or assessments of the client. f. The frequency of sessions of supervision of staff and type of personnel who will supervise staff. g. The extent to which payment may be expected form a third party payer. h. The charges for service that will not be covered by a third party payer. i. The charges the individual may have to pay j. A contingency plan for circumstances when services cannot be provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 870		
0 875 SS=E	144A.4791, Subd. 10 Termination of Service Plan Subd. 10. Termination of service plan. (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information: (1) the effective date of termination; (2) the reason for termination; (3) a list of known licensed home care providers in the client's immediate geographic area; (4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill	0 875		

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BUTTERFLY BOUND CARE	5701 SHINGLE CREEK PARKWAY SUITE 318D BROOKLYN CENTER, MN 55430

(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
0 875	Continued From page 11 of rights, section 144A.44, subdivision 1, clause (17); (5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and (6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment. (b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure the termination of services notice, given to two of two clients (C1 and C2) reviewed contained the required elements. Neither C1's nor C2's termination of services contained information of a list of known licensed home care providers in the client's immediate geographic area or a statement that the termination does not constitute notice of termination of housing with services contract with a housing with services establishment. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a	0 875		

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0 875	Continued From page 12 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). Findings include: C1's record was reviewed. C1 moved into the facility on August 8, 2019 due to diagnoses that included mood swings, chronic hepatitis, hypothyroidism, and opioid dependency. C1's service plan dated August 9, 2019 indicated C1 received 24 hour customized care (services not specified) from the home care provider. C1's Eviction notice dated September 6, 2019 indicated that the licensee was unable to meet C1's needs for the following reasons: "1. We are unable to control the loud angry outbursts behavior that will result into putting other clients at risk. 2. Verbally aggressive and disrespectful behavior towards staff." The notice indicated C1 was required to vacate the premises by or before October 5, 2019. C1's progress note dated October 7, 2019 indicated C1 was discharged on October 5, 2019. C2's record was reviewed. C2 moved into the facility on March 20, 2019 due to diagnoses that included stroke with hemiparesis, type two diabetes, hypertension, and obstructive sleep apnea. C2's service plan dated March 20, 2019 indicated C2 received service from the home care provider that included meal preparation, assistance with activities of daily living, toileting, transfers, blood glucose monitoring, medication administration, nail care, and wound care.	0 875		

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0 875	Continued From page 13 C2's eviction notice dated September 4, 2019 indicated the reason for eviction was "violation of the following: 1. Verbally aggressive, demeaning, and disrespectful behavior towards staff. 2. We are unable to control the loud angry outbursts (behavior) which will result in putting the other clients at risk." The notice indicated the licensee "will not be your housing with service provider starting September 4, 2019". The notice indicated that C2 was "required to vacate the premises on or before October 4, 2019". During an interview on January 29, 2020 at 10:10 a.m., C2 stated he did not have to leave the facility. The Service Plan policy (undated) indicated if the home care provider terminates a service plan with the client, and the client continues to need home care services, the provider will provide the client and the client's representative, if any, with a written notice of termination that includes the following: Effective date of termination; reason for termination; list of known licensed home care providers in the client's immediate geographic area; statement that the provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver; the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with service contract with a housing with services establishment. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 875		

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01065	Continued From page 14	01065		
01065 SS=C	144A.4794, Subd. 1(b) Protecting Client Records (b) Client records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The home care provider shall establish and implement written procedures to control use, storage, and security of client's records and establish criteria for release of client information. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to protect client records against loss, tampering, or unauthorized disclosure when three of three client records (C2, C3, and C4) reviewed were stored on an unlocked shelf in a common living room area. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, 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). Findings include: During an observation on January 29, 2020 at 10:15 a.m., client medical records for C2, C3, and C4 were observed sitting on an open, unsecured	01065		

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01065	Continued From page 15 bookshelf in the living room of the facility. At the time, a window salesperson (who walked around the home checking windows) and all the clients present had access to the client records. C2's record was reviewed. C2 moved into the facility on March 20, 2019 due to diagnoses that included stroke with hemiparesis, type two diabetes, hypertension, and obstructive sleep apnea. C2's service plan dated March 20, 2019 indicated C2 received service from the home care provider that included meal preparation, assistance with activities of daily living, toileting, transfers, blood glucose monitoring, medication administration, nail care, and wound care. C3's record was reviewed. C3 moved into the facility on October 9, 2019 due to diagnoses that included stroke with slurred speech and changes to cognition, diabetes, chronic kidney disease, and depression. C3's service plan dated October 9, 2019 indicated C3 received 24 hour customized care (services not specified) from the home care provider. C4's record was reviewed. C4 moved into the facility on March 20, 2019 due to diagnoses that included end stage renal disease with dialysis, hypertension, anemia, and chronic pain. C4's service plan dated March 20, 2019 indicated C4 received 24 hour customized care from the home care provider that included assistance with activities of daily living, meals, mediation, monitoring, activities, assistance with transfers, and grooming. During an interview on January 29, 2020 at 1:30 p.m. owner (O)-B stated she did not think there was a problem with the records being on the bookshelf. O-B stated she wanted staff to have access to the client records in case they had to	01065		

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01065	Continued From page 16 send someone to the hospital. The Clinical Record Confidentiality policy (undated) indicated all client information shall be treated as confidential and available only to authorized users. The policy indicated that the licensee would store clinical records in a locked cabinet or room and when in use, not left unattended in areas accessible to unauthorized individuals. TIME PERIOD FOR CORRECTION: Seven (7) days	01065		
01225 SS=F	144A.4797, Subd. 3 Supervision of Staff - Comp 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 must include observation of the staff administering the medication or treatment and the interaction with the client. (b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care	01225		

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01225	Continued From page 17 provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure the registered nurse (RN)-D conducted direct supervision of staff performing delegated nursing tasks within 30 days of hire for one of one unlicensed personnel (ULP)-C whose personnel file was reviewed. Based on interview an additional nine of nine unlicensed personnel did not receive supervision by RN-C after 30 days employment or for periodic supervision. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). Findings include: The licensee hired ULP-C on March 22, 2019 to provide direct care and delegated nursing tasks. ULP-C's time cards indicated ULP-C worked the following dates and times: April 5, 2019 4:00 p.m. to 10:36 p.m., April 6, 2019 8:00 a.m. to 4:00 p.m., April 7, 2019 10:30 a.m. to 4:00 p.m., April 12, 2019 4:00 p.m. to 10:00 p.m., April 13, 2019 8:00 a.m. to 3:20 p.m., April 19, 2019 3:50 p.m. to 10:00 p.m., April 20, 2019 8:00 a.m. to 4:00 p.m.,	01225		

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01225	Continued From page 18 April 21, 2019 8:00 a.m. to 4:00 p.m., April 26, 2019 3:55 p.m. to 10:10 p.m., May 3, 2019 3:50 p.m. to 10:30 p.m., May 5, 2019 4:00 p.m. to 8:10 p.m., May 10, 2019 2:30 p.m. to 10:00 p.m., May 11, 2019 4:00 p.m. to 10:00 p.m., May 17, 2019 4:00 p.m. to 10:00 p.m., May 18, 2019 8:00 a.m. to 4:00 p.m., May 19, 2019 9:00 a.m. to 4:00 p.m., May 24, 2019 4:00 p.m. to 10:00 p.m., May 25, 2019 4:00 p.m. to 10:00 p.m., May 26, 2019 4:00 p.m. to 10:00 p.m., August 17, 2019 8:00 a.m. to 4:00 p.m., August 18, 2019 8:00 a.m. to 4:40 p.m., September 1, 2019 8:00 a.m. to 4:00 p.m., September 7, 2019 4:00 p.m. to 12:00 a.m., September 8, 2019 3:00 p.m. to 12:00 a.m., and Friday (undated, but reported by owner (O)-B to be September 20, 2019) 5:00 p.m. to 12:20 a.m. ULP-C's employee file lacked evidence of direct supervision within 30 days of employment and periodic supervision. During an interview on January 29, 2019 at 11:36 a.m., ULP-A stated RN-D provided training three years ago and "she used to come to inspect us". During an interview on January 29, 2019 at 2:57 p.m., owner (O) - B stated she does not have documentation of supervision of any of the staff including ULP-C and nine of nine active employees. During an interview on January 30, 2019 at 12:37 p.m. RN-D stated she was not aware that supervision of unlicensed personnel was required. RN-D reports she had not documented any supervision. The Supervision of Unlicensed Personnel policy (undated) indicated that the licensee designated registered nurse must review the client care plan	01225		

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01225	Continued From page 19 with the unlicensed staff prior to caring for the client. The registered nurse provides supervision of staff performing medication or treatment administration and must include observation of the staff administering the medication or treatment and the interaction with the client. Direct supervision of staff performing delegated tasks must be provided within thirty days after the individual begins working for the provider and thereafter as needed based on performance. If the care plan is complex and/or the clients condition unstable the registered nurse will supervise and instruct the unlicensed personnel on the first day of the assignment in person and as often as necessary thereafter. TIME PERIOD FOR CORRECTION: Seven (7)	01225		
02015 SS=D	626.557, Subd. 3 Timing of Report 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 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: (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	02015		

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02015	Continued From page 20 (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). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (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 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.	02015		

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02015	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report all suspected allegations of maltreatment to the State Agency for one of one clients (C1) reviewed. Police informed owner (O)-B of an allegation that unlicensed personnel (ULP)-C had sex with C1. O-B failed to make a report to the state agency. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's record was reviewed. C1 moved into the facility on August 8, 2019 due to diagnoses that included mood swings, chronic hepatitis, hypothyroidism, and opioid dependency. C1's service plan dated August 9, 2019 indicated C1 received 24 customized care (services not specified). A police report dated September 24, 2019 indicated police went to the facility at 11:45 p.m. to follow up on a report that unlicensed personnel (ULP)-C had sex with C1 on September 20, 2019 between 9:30 p.m. and 10:00 p.m., gave C1 money afterward, and told C1 not to tell or C1 would get kicked out of the facility. The report indicated an officer spoke to owner (O)-B about the allegation and gathered information from O-B. During an interview on January 29, 2020 at 2:57	02015		

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02015	Continued From page 22 p.m. O-B stated she did not report the allegation to the state agency, but knows that she should have. During an interview on January 30, 2020 at 12:37 p.m., registered nurse (RN)-D stated O-B informed her of the allegation but did not report to the state agency because she did not know that she was supposed to report. The Vulnerable Adult policy (undated) indicated all staff are mandated to report maltreatment immediately to the supervisor or the Minnesota Abuse Reporting Center (MAARC) to ensure that all suspected cases of adult maltreatment are reported under the statutes and to protect those who are vulnerable to abuse or neglect. TIME PERIOD FOR CORRECTION: SEVEN (7) days	02015		