DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Serenity Living Solutions of Sebeka

Facility Address:
1005 Wells Avenue West

Facility City:
Sebeka

State: Minnesota | **ZIP:** 56477 | **County:** Wadena

Report Number:
HL32493006 and HL32493007

Date of Visit:
January 19, 2018

Time of Visit:
8:15 a.m. to 5:30 p.m.

Date Concluded:
March 9, 2018

Investigator's Name and Title:
Rhylee Gilb, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the alleged perpetrator (AP) failed to assess the client or contact emergency medical services when the client was hypertensive and asked to be sent to an emergency room and when direct care staff asked the AP to send the client to the emergency room. The next day, the client was found to have suffered a heart attack and the client died within a week of the incident.

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

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

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect is substantiated. The alleged perpetrator (AP) failed to properly assess a client's report of a significant change in condition, and failed to provide needed care in response to the emergency. The client experienced a significantly elevated blood pressure, low oxygen saturation, and chest pain. The client asked to be evaluated at the hospital, but the AP instructed staff not to send the client to the hospital, and the client died of a heart attack.

The client received services from a provider licensed as a comprehensive home care provider. The client was admitted with diagnosis that included chronic obstructive pulmonary disease. The client's service plan indicated the client required assistance with bathing, managing incontinent products, and medication administration. The client required supervision assistance with dressing and grooming. In addition, the client was independent with transferring and mobility.

Approximately two weeks before the incident, the client was evaluated by a nurse practitioner following

rectal bleeding. The cause was related to hemorrhoids and the nurse practitioner noted the client's lab work was essentially normal.

On the day of the incident, the client was not feeling well and was having shortness of breath. By the evening, the client was coughing a lot, had increased weakness, and an incontinent bowel movement. The home health aide (HHA) assisted the client to the bathroom and the client told him/her s/he felt awful and wanted to go in to see the doctor. The HHA took the client's vital signs, and the client's systolic blood pressure was over 200 and the diastolic was approximately 125. The client's oxygen saturation was 78% on room air. The HHA stated the client was also "burning up," and opened a window to help cool him off. The HHA called the AP, who was the nurse on-call, to report the client's symptoms, vitals, and desire to go to the hospital. The HHA reported the AP refused to allow the client to be sent to the hospital and instructed the HHA to administer oxygen and Tylenol to the client. The HHA believed the client needed to go to the emergency room and called the AP four times throughout that night because the client was pale, seemed to have a fever, and was shaky. However, the AP still refused. The HHA stated s/he would have been fired if s/he sent someone to the hospital without a nurse approval, but stated s/he wished s/he would have done so.

Review of medical records indicated that the vital signs measured by the direct care staff during the evening were not documented. Multiple staff indicated that the AP had previously instructed direct care staff not to write progress notes.

The next morning, the AP arrived to the home care provider and assessed the client. The client's oxygen saturation was 92% on two liters per minute of oxygen. The client had chest pain and wheezing from both lungs. The AP had another staff member drive the client to an urgent care. While enroute, the client's physician returned a page and instructed the client be brought straight to the emergency room, not to urgent care.

The client was admitted to the hospital and diagnosed with a heart attack and chronic obstructive pulmonary disease. The next day the client was transferred the intensive care unit and died six days later. The client's death record indicated cause of death was a cardiac arrest (heart attack).

During an interview with the client's physician, the physician stated the home care provider presented the information on the client like s/he had an abrupt change in condition that morning and wanted to send him/her to urgent care. The physician stated if the vitals and symptoms that the HHA reported were reported to him/her, s/he would have instructed the client be sent to the hospital immediately by ambulance. The physician stated there were interventions that could have been done if the client was in the process of having a heart attack and if s/he had been sent in sooner, it could have made a huge difference in his/her outcome. The physician stated the home care provider had been difficult to work with as they tend to "brush off" issues and concerns that s/he has brought to their attention regarding his/her patients.

During an interview with the client's family member, the family member stated s/he visited the client in the hospital. The client told him/her s/he was in pain all night before arriving the hospital. The family member asked the client why s/he did not report how s/he was feeling to anyone and the client replied, "I did."

During an interview with the AP, the AP stated when the HHA called s/he was not provided with vitals other than the client's oxygen saturation. The AP stated the HHA's did nothing that s/he instructed, which was to administer oxygen and Tylenol. The AP did say s/he was called all night by both the evening shift and night shift staff.

Correction orders were issued regarding client rights, assessment, client records, and reporting of maltreatment.

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 alleged perpetrator is responsible for the neglect, because s/he was responsible for assessing the client when the client experienced a change in condition. The alleged perpetrator directed staff not to send the client to the hospital even when the client asked to be evaluated by a physician.
The facility is also responsible for the neglect because multiple staff failed to contact emergency medical services when the client's symptoms, vital signs, and request indicated the client required further evaluation and treatment.

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 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.

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] Medication Administration Records
- [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] Death Certificate [x] Other, specify:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [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 is deceased

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 is deceased

Did you interview additional residents? ◯ Yes ◉ No

Total number of resident interviews: None

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ◯ No

Total number of staff interviews: Twelve

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:

☒ Dignity/Privacy Issues

☒ 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: N/A

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Crow Wing County Attorney

Crow Wing County Medical Examiner

Pequot Lakes Police Department

Pequot Lakes City Attorney

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	H32493	A. BUILDING: _____ B. WING _____	C 02/08/2018

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SERENITY LIVING SOLUTIONS OF SEBEKA	1005 WELLS AVE W SEBEKA, MN 56477

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders have 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 January 19, 2018, a complaint investigation was initiated to investigate complaints #HL32493006 and HL32493007. At the time of the survey, there were 33 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 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. 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 Minn. Stat. 144A.474 subd. 11 (b) (1) (2).	
0 325 SS=J	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 interview and document review, the licensee failed to ensure freedom from maltreatment (neglect) for 1 of 3 clients (C3) reviewed when the licensee failed to assess a significant change in condition or provide emergency care. C3 experienced a significantly elevated blood pressure, low oxygen saturation, and chest pain. C3 requested to be evaluated by a physician, but the home care provider nurse directed staff not to contact emergency medical services. C3 died of a heart attack. This practice resulted in a level four violation (a violation that results in 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). The findings include: C3's medical record was reviewed. C3 was admitted with the diagnosis of chronic obstructive pulmonary disease. C3's service plan, dated December 1, 2017 indicated C3 required supervision assistance with dressing and grooming. C3 required assistance with bathing, managing incontinent products, and medication administration. C3 was independent with transferring and mobility.	0 325		

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0 325	Continued From page 2 C3's provider visits were reviewed. C3 was seen by NP-T on November 29, 2017 for a follow up visits. C3 had been to the emergency room the previous day on November 28, 2017 for rectal bleeding. NP-T dictated cause of bleeding was likely related to hemorrhoids. NP-T noted C3's lab work was essentially normal. C3's assessment were reviewed. C3's admission RN assessment was completed December 5, 2017. C3 had an undated 14 day assessment completed. During an interview on January 31, 2018 at 2:55 p.m., HHA-K stated she worked with C3 on December 13, 2017 during the evening shift. C3 coughed a lot and stated he felt awful. C3 had an incontinent bowel movement and HHA-K assisted him in the bathroom. C3 told her he wanted to go the doctor. HHA-K took C3's vitals. HHA-K stated she could not remember his exact blood pressure but the systolic was over 200 and the diastolic was over 125. C3's oxygen saturation was very low, but HHA-K could not remember the number. HHA-K stated she had wrote the vitals on a scratch piece of paper to report them to RN-C, who was on-call. HHA-K stated she reported C3 vitals, his symptoms, and that C3 wanted to go to the doctor. HHA-K stated RN-C refused to send C3 to the hospital and told her C3 would be fine, and someone would look at him in the morning. RN-C instructed HHA-K to put oxygen on C3 and give him Tylenol. HHA-K stated she called RN-C four times that night, requesting to send C3 to the hospital. HHA-K stated C3 was white, had a fever, and was shaky. HHA-K stated she was not allowed to send someone to the hospital without the nurse approval or she would be fired. C3's progress notes were reviewed. On	0 325		

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0 325	Continued From page 3 December 14, 2017, RN-C wrote C3 complained of chest hurting with breathing and had wheezing in both lungs. C3's oxygen saturation was 92% on oxygen at two liters per minute. RN-C had the float (HHA-H) drive C3 to urgent care. At 8:00 a.m., C3's medical doctor (MD)-P called and instructed C3 to be brought directly to the emergency and not to urgent care. C3's progress note dated December 14, 2017, LPN-F dictated C3 was admitted to the hospital for a heart attack and chronic obstructive pulmonary disease. On December 15, 2017 C3 was transferred to the intensive care unit. C3' death record indicated C3 died on December 21, 2017 and the cause of death was cardiac arrest (heart attack). During an interview on February 5, 2018 at 4:20 p.m. FM-Q stated she visited C3 in the hospital. C3 told her he was in pain all night before arriving the hospital. FM-Q asked C3 why he did not report how he was feeling to anyone and stated C3 replied, "I did." During an interview on February 6, 2018 at 1:40 p.m., MD-Q stated the licensee presented the information on C3 like he had an abrupt change in condition that morning and wanted to send him to urgent care. MD-Q instructed that he needed to be seen in the emergency room. MD-Q stated if the vitals and symptoms that HHA-K reported were reported to her, she would have instructed that C3 be sent to the hospital immediately by ambulance. MD-Q stated there were interventions that could have been done if he was in the process of having a heart attack and if he had been sent in sooner it could have made a huge difference in his outcome.	0 325		

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0 325	Continued From page 4 The licensee policy titled Assessment-Schedules dated January 1, 2018 indicated an RN will assess the client as indicated by any change in condition. TIME PERIOD OF CORRECTION: Seven days	0 325		
0 645 SS=D	144A.475, Subd. 1 Conditions Subdivision 1. Conditions. (a) The commissioner may refuse to grant a temporary license, renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider: (1) is in violation of, or during the term of the license has violated, any of the requirements in sections144A.471 to 144A.482; (2) permits, aids, or abets the commission of any illegal act in the provision of home care; (3) performs any act detrimental to the health, safety, and welfare of a client; (4) obtains the license by fraud or misrepresentation; (5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the home care provider's books,	0 645		

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0 645	Continued From page 5 records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the home care provider's clients; (8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department; (9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter; (10) refuses to initiate a background study under section 144.057 or 245A.04; (11) fails to timely pay any fines assessed by the department; (12) violates any local, city, or township ordinance relating to home care services; (13) has repeated incidents of personnel performing services beyond their competency level; or (14) has operated beyond the scope of the home care provider's license level. (b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.	0 645		

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0 645	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee interfered with the investigation by the Department of Health by deleting a component of the client record which was requested by the Department of Health. 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). The findings include: During an interview on January 19, 2018 at 4:45 p.m., anonymous staff (AS)-D stated on December 8, 2017, HHA-G reported registered nurse (RN)-C made her delete an progress note entry she had made on C1 on November 11, 2017, while employed by the previous home care provider. AS-D stated she had received a phone call from the State Department of Health inquiring about C1 and transferred the phone call to RN-C. AS-D saw on RN-C's desk faxed paperwork on C1, including the progress notes and observed, the entry made by HHA-G was not included. During an interview on January 22, 2018 at 3:35 p.m., AS-B stated HHA-G reported RN-C made her delete her progress note. AS-B went into the electronic system and verified the note was deleted and reviewed the deleted note. AS-B stated RN-C reported she had to give further	0 645		

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0 645	Continued From page 7 system access to HHA-G in order for the note to be deleted. AS-B stated she informed house manager (HM)-A, and HM-A stated she was aware the note was deleted. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on November 11, 2017, she made a progress note in C1's electronic record. HHA-G stated she was instructed to make the note and place oxygen on C1 that Saturday evening by RN-C, who was on-call. HHA-G stated on December 8, 2017, the coroner called regarding C1 and RN-C told her she needed to remove her note. HHA-G stated RN-C reprimanded her for making the note and stated she was not allowed to make nurse notes and was in violation of the licensee policy. HHA-G stated RN-C gave her administrative access to remove the note. HHA-G stated she knew it was wrong to remove a note from a medical record, and reported it. During an on-site visit on January 19, 2018, the deleted note was recovered from the electronic medical record. The note was verified that it was entered on November 11, 2017 by HHA-G. The note read: "Resident found in room tonight at about 9:30 with a strong wheezing gurgling sound from what appears to be her throat, listen to lungs and didn't appear to noise from them. Her temp was at 95.1 O2/82 P/96 R/15 BP/85/50. Put resident on oxygen at 2 liters residents O2 went up to 87 within 15 minutes. Monitoring BP and O2." (O2 = oxygen saturation, P = pulse, R = respirations and BP = blood pressure). The note was verified have be been deleted on December 8, 2017 and it was verified the State Department of Health had contacted the licensee for information regarding C1. C1's progress notes for November 2017 had three other HHA staff make	0 645		

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(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
0 645	Continued From page 8 an entry, aside from HHA-G. During an interview on January 19, 2017 at 5:00 p.m., HM-A stated she was aware of the deleted note. RN-C disciplined HHA-G because she wrote a note and was not a nurse. When inquired why HHA-G was disciplined and note the other three HHA's, HM-A stated because HHA-G applied oxygen without a doctors order and was not supposed to provide a treatment. During an interview on February 6, 2018 at 9:47 a.m., RN-C stated applying oxygen was a part of the licensee standing orders and she taught all HHA's house to use an E-tank (oxygen) during the oxygen class. TIME PERIOD OF CORRECTION: Seven days	0 645		
0 805 SS=J	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 maltreatment are reported. This MN Requirement is not met as evidenced by:	0 805		

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	H32493	A. BUILDING: _____ B. WING _____	C 02/08/2018

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0 805	Continued From page 9 Based on interview and document review, the licensee failed to investigate and report suspected maltreatment (neglect) of vulnerable adults for 1 of 3 clients (C3) reviewed. C3 experienced a significantly elevated blood pressure, low oxygen saturation, and chest pain. C3 requested to be evaluated by a physician, but the home care provider nurse directed staff not to contact emergency medical services. C3 died of a heart attack. The licensee did not investigate the incident or report it as possible maltreatment. This practice resulted in a level four violation (a violation that results in 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). The findings include: C3's medical record was reviewed. C3 was admitted with the diagnosis of chronic obstructive pulmonary disease. C3's service plan, dated December 1, 2017 indicated C3 required supervision assistance with dressing and grooming. C3 required assistance with bathing, managing incontinent products, and medication administration. C3 was independent with transferring and mobility. C3's provider visits were reviewed. C3 was seen by NP-T on November 29, 2017 for a follow up visits. C3 had been to the emergency room the previous day on November 28, 2017 for rectal bleeding. NP-T dictated cause of bleeding was likely related to hemorrhoids. NP-T noted C3's lab work was essentially normal.	0 805		

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0 805	Continued From page 10 C3's assessment were reviewed. C3's admission RN assessment was completed December 5, 2017. C3 had an undated 14 day assessment completed. During an interview on January 31, 2018 at 2:55 p.m., HHA-K stated she worked with C3 on December 13, 2017 during the evening shift. C3 coughed a lot and stated he felt awful. C3 had an incontinent bowel movement and HHA-K assisted him in the bathroom. C3 told her he wanted to go the doctor. HHA-K took C3's vitals. HHA-K stated she could not remember his exact blood pressure but the systolic was over 200 and the diastolic was over 125. C3's oxygen saturation was very low, but HHA-K could not remember the number. HHA-K stated she had wrote the vitals on a scratch piece of paper to report them to RN-C, who was on-call. HHA-K stated she reported C3 vitals, his symptoms, and that C3 wanted to go to the doctor. HHA-K stated RN-C refused to send C3 to the hospital and told her C3 would be fine, and someone would look at him in the morning. RN-C instructed HHA-K to put oxygen on C3 and give him Tylenol. HHA-K stated she called RN-C four times that night, requesting to send C3 to the hospital. HHA-K stated C3 was white, had a fever, and was shaky. HHA-K stated she was not allowed to send someone to the hospital without the nurse approval or she would be fired. HHA-K stated December 2017, the licensee quit using the electronic medical record and changed to paper charting. HHA-K stated the HHA's were instructed by management they were not allowed to document client status in the client records and therefore was not able to document C3 vitals or status on December 13, 2017. HHA-K stated she was told staff would be fired if went against the nurses instruction and stated she wished she would have sent C3 to hospital despite RN-C's	0 805		

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0 805	Continued From page 11 orders. C3's progress notes were reviewed. On December 14, 2017, RN-C wrote C3 complained of chest hurting with breathing and had wheezing in both lungs. C3's oxygen saturation was 92% on oxygen at two liters per minute. RN-C had the float (HHA-H) drive C3 to urgent care. At 8:00 a.m., C3's medical doctor (MD)-P called and instructed C3 to be brought directly to the emergency and not to urgent care. C3's progress note dated December 14, 2017, LPN-F dictated C3 was admitted to the hospital for a heart attack and chronic obstructive pulmonary disease. On December 15, 2017 C3 was transferred to the intensive care unit. C3' death record indicated C3 died on December 21, 2017 and the cause of death was cardiac arrest (heart attack). During an interview on February 5, 2018 at 4:20 p.m. FM-Q stated she visited C3 in the hospital. C3 told her he was in pain all night before arriving the hospital. FM-Q asked C3 why he did not report how he was feeling to anyone and stated C3 replied, "I did." During an interview on February 6, 2018 at 9:47 a.m., RN-C stated C3's oxygen saturation was reported by HHA-K as 78% on December 13, 2017. The licensee lacked an internal investigation regarding the incident and there was no record that the licensee reported the incident to the Minnesota Adult Abuse Reporting Center. The licensee policy Vulnerable Adult- Keeping	0 805		

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0 805	Continued From page 12 Our Residents Safe dated January 1, 2016, indicated all employees are provided training regarding their obligation and responsibility to report suspected maltreatment to managers, the RN and to the Minnesota Adult Abuse Reporting Center. The manager or RN will investigate the situation and sentinel events will be reported to the direct supervisor and vice president. TIME PERIOD OF CORRECTION: Seven days	0 805		
0 860 SS=J	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring	0 860		

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0 860	Continued From page 13 and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to assess a significant change in condition for 1 of 3 clients (C3) reviewed. C3 experienced a significantly elevated blood pressure, low oxygen saturation, and chest pain. C3 requested to be evaluated by a physician, but the home care provider nurse directed staff not to contact emergency medical services. C3 died of a heart attack. This practice resulted in a level four violation (a violation that results in 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). The findings include: C3's medical record was reviewed. C3 was admitted with the diagnosis of chronic obstructive pulmonary disease. C3's service plan, dated December 1, 2017 indicated C3 required supervision assistance with dressing and grooming. C3 required assistance with bathing, managing incontinent products, and medication administration. C3 was independent with transferring and mobility. C3's provider visits were reviewed. C3 was seen by NP-T on November 29, 2017 for a follow up visits. C3 had been to the emergency room the	0 860		

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0 860	Continued From page 14 previous day on November 28, 2017 for rectal bleeding. NP-T dictated cause of bleeding was likely related to hemorrhoids. NP-T noted C3's lab work was essentially normal. C3's assessment were reviewed. C3's admission RN assessment was completed December 5, 2017. C3 had an undated 14 day assessment completed. During an interview on January 31, 2018 at 2:55 p.m., HHA-K stated she worked with C3 on December 13, 2017 during the evening shift. C3 coughed a lot and stated he felt awful. C3 had an incontinent bowel movement and HHA-K assisted him in the bathroom. C3 told her he wanted to go the doctor. HHA-K took C3's vitals. HHA-K stated she could not remember his exact blood pressure but the systolic was over 200 and the diastolic was over 125. C3's oxygen saturation was very low, but HHA-K could not remember the number. HHA-K stated she had wrote the vitals on a scratch piece of paper to report them to RN-C, who was on-call. HHA-K stated she reported C3 vitals, his symptoms, and that C3 wanted to go to the doctor. HHA-K stated RN-C refused to send C3 to the hospital and told her C3 would be fine, and someone would look at him in the morning. RN-C instructed HHA-K to put oxygen on C3 and give him Tylenol. HHA-K stated she called RN-C four times that night, requesting to send C3 to the hospital. HHA-K stated C3 was white, had a fever, and was shaky. HHA-K stated she was not allowed to send someone to the hospital without the nurse approval or she would be fired. C3's progress notes were reviewed. On December 14, 2017, RN-C wrote C3 complained of chest hurting with breathing and had wheezing in both lungs. C3's oxygen saturation was 92% on	0 860		

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0 860	Continued From page 15 oxygen at two liters per minute. RN-C had the float (HHA-H) drive C3 to urgent care. At 8:00 a.m., C3's medical doctor (MD)-P called and instructed C3 to be brought directly to the emergency and not to urgent care. C3's progress note dated December 14, 2017, LPN-F dictated C3 was admitted to the hospital for a heart attack and chronic obstructive pulmonary disease. On December 15, 2017 C3 was transferred to the intensive care unit. C3' death record indicated C3 died on December 21, 2017 and the cause of death was cardiac arrest (heart attack). During an interview on February 5, 2018 at 4:20 p.m. FM-Q stated she visited C3 in the hospital. C3 told her he was in pain all night before arriving the hospital. FM-Q asked C3 why he did not report how he was feeling to anyone and stated C3 replied, "I did." During an interview on February 6, 2018 at 1:40 p.m., MD-Q stated the licensee presented the information on C3 like he had an abrupt change in condition that morning and wanted to send him to urgent care. MD-Q instructed that he needed to be seen in the emergency room. MD-Q stated if the vitals and symptoms that HHA-K reported were reported to her, she would have instructed that C3 be sent to the hospital immediately by ambulance. MD-Q stated there were interventions that could have been done if he was in the process of having a heart attack and if he had been sent in sooner it could have made a huge difference in his outcome. The licensee policy titled Assessment-Schedules dated January 1, 2018 indicated an RN will	0 860		

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0 860	Continued From page 16 assess the client as indicated by any change in condition. TIME PERIOD OF CORRECTION: Seven days	0 860		
01080 SS=E	144A.4794, Subd. 3 Contents of Client Record Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the	01080		

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01080	Continued From page 17 client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights; (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain client records for 2 of 3 client's (C1, C3) reviewed. C1's progress note from a previous home care provider about a change in condition was deleted from the electronic record and home health staff were instructed they could no longer document in the client records. Because of that direction, vitals signs were not documented for C3 during a change of condition. 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	01080		

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01080	Continued From page 18 a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1's medical record was reviewed. C1 was admitted to the previous home care provider with diagnoses that included schizophrenia and asthma. C1's undated service plan indicated C1 was independent with ambulation with a walker, dressing, grooming, eating, and toileting. C1 was continent. C1 required assistance with bathing and medication administration. C1 previous progress notes were reviewed. On November 10, 2017, home health aide (HHA)-J made an entry indicating C1 had loose stools all shift and C1 had back pain. On November 12, 2017, licensed practical nurse (LPN)-E made an entry indicating C1 had low oxygen, low blood pressure, loose stools, and was lethargic. C1 was transported to the hospital. C1's hospital records were reviewed. On November 12, 2017, C1 was diagnosed with septic shock (total body infection) and renal failure. C1 was intubated (started artificial breathing), given antibiotics, and intravenous fluids. C1's condition worsened and was transferred to a secondary hospital on November 13, 2017. At the secondary hospital, C1 underwent exploratory surgery, confirmed sepsis was related to clostridium difficile, and had a removal of her colon. Despite life saving efforts, C1 died on November 14, 2017. C1's death record indicated cause of death was related to clostridium difficile and septic shock. During an interview on January 19, 2018 at 4:45	01080		

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01080	Continued From page 19 p.m., anonymous staff (AS)-D stated on December 8, 2017, HHA-G reported registered nurse (RN)-C made her delete an progress note entry she had made on C1 on November 11, 2017, while employed by the previous home care provider. AS-D stated she had received a phone call from the State Department of Health inquiring about C1 and transferred the phone call to RN-C. AS-D saw on RN-C's desk faxed paperwork on C1, including the progress notes and observed, the entry made by HHA-G was not included. During an interview on January 22, 2018 at 3:35 p.m., AS-B stated HHA-G reported RN-C made her delete her progress note. AS-B went into the electronic system and verified the note was deleted and reviewed the deleted note. AS-B stated RN-C reported she had to give further system access to HHA-G in order for the note to be deleted. AS-B stated she informed house manager (HM)-A, and HM-A stated she was aware the note was deleted. During an interview on January 31, 2018 at 2:00 p.m., HHA-G stated on November 11, 2017, she made a progress note in C1's electronic record. HHA-G stated she was instructed to make the note and place oxygen on C1 that Saturday evening by RN-C, who was on-call. HHA-G stated on December 8, 2017, the coroner called regarding C1 and RN-C told her she needed to remove her note. HHA-G stated RN-C reprimanded her for making the note and stated she was not allowed to make nurse notes and was in violation of the licensee policy. HHA-G stated RN-C gave her administrative access to remove the note. HHA-G stated she knew it was wrong to remove a note from a medical record, and reported it.	01080		

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01080	Continued From page 20 During an on-site visit on January 19, 2018, the deleted note was recovered from the electronic medical record. The note was verified that it was entered on November 11, 2017 by HHA-G. The note read: "Resident found in room tonight at about 9:30 with a strong wheezing gurgling sound from what appears to be her throat, listen to lungs and didn't appear to noise from them. Her temp was at 95.1 O2/82 P/96 R/15 BP/85/50. Put resident on oxygen at 2 liters residents O2 went up to 87 within 15 minutes. Monitoring BP and O2." (O2 = oxygen saturation, P = pulse, R = respirations and BP = blood pressure). The note was verified have be been deleted on December 8, 2017 and it was verified the State Department of Health did contact the licensee for information regarding C1. C1's progress notes for November 2017 had three other HHA staff make an entry, aside from HHA-G. During an interview on January 19, 2017 at 5:00 p.m., HM-A stated she was aware of the deleted note. RN-C disciplined HHA-G because she wrote a note and was not a nurse. When inquired why HHA-G was disciplined and note the other three HHA's, HM-A stated because HHA-G applied oxygen without a doctors order and was not supposed to provide a treatment. During an interview on February 6, 2018 at 9:47 a.m., RN-C stated applying oxygen was a part of the licensee standing orders and she taught all HHA's house to use an E-tank (oxygen) during the oxygen class. C3's medical record was reviewed. C3 was admitted with the diagnosis of chronic obstructive pulmonary disease. C3's service plan, dated December 1, 2017 indicated C3 required	01080		

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01080	Continued From page 21 supervision assistance with dressing and grooming. C3 required assistance with bathing, managing incontinent products, and medication administration. C3 was independent with transferring and mobility. During an interview on January 31, 2018 at 2:55 p.m., HHA-K stated she worked with C3 on December 13, 2017 during the evening shift. C3 coughed a lot and stated he felt awful. C3 had an incontinent bowel movement and HHA-K assisted him in the bathroom. C3 told her he wanted to go the doctor. HHA-K took C3's vitals. HHA-K stated she could not remember his exact blood pressure but the systolic was over 200 and the diastolic was over 125. C3's oxygen saturation was very low, but HHA-K could not remember the number. HHA-K stated she had wrote the vitals on a scratch piece of paper to report them to RN-C, who was on-call. HHA-K stated she reported C3 vitals, his symptoms, and that C3 wanted to go to the doctor. HHA-K stated RN-C refused to send C3 to the hospital and told her C3 would be fine, and someone would look at him in the morning. RN-C instructed HHA-K to put oxygen on C3 and give him Tylenol. HHA-K stated she called RN-C four times that night, requesting to send C3 to the hospital. HHA-K stated C3 was white, had a fever, and was shaky. HHA-K stated she was not allowed to send someone to the hospital without the nurse approval or she would be fired. HHA-K stated during December 2017, the licensee quit using the electronic medical record and changed to paper charting. HHA-K stated the HHA's were instructed by management they were not allowed to document client status in the client records and therefore was not able to document C3's vital signs or status on December 13, 2017. C3's progress notes were reviewed. On	01080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32493	A. BUILDING: _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY LIVING SOLUTIONS OF SEBEKA	1005 WELLS AVE W SEBEKA, MN 56477

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01080	Continued From page 22 December 14, 2017, RN-C wrote C3 complained of chest hurting with breathing and had wheezing in both lungs. C3's oxygen saturation was 92% on oxygen at two liters per minute. RN-C had the float (HHA-H) drive C3 to urgent care. At 8:00 a.m., C3's medical doctor (MD)-P called and instructed C3 to be brought directly to the emergency and not to urgent care. C3's progress note dated December 14, 2017, LPN-F dictated C3 was admitted to the hospital for a heart attack and chronic obstructive pulmonary disease. On December 15, 2017 C3 was transferred to the intensive care unit. C3' death record indicated C3 died on December 21, 2017 and the cause of death was cardiac arrest (heart attack). During an interview on January 19, 2017 at 9:15 a.m., HM-A stated with the licensee reverted back to paper medical records on December 1, 2017. During an interview on February 6, 2018 at 9:47 a.m., RN-C stated C3's oxygen saturation was reported by HHA-K as 78% on December 13, 2017. The licensee policy titled Record Retention dated January 1, 2016, indicated all records will be retained for seven years after a client's discharge. TIME PERIOD OF CORRECTION: Seven days	01080		
02015 SS=J	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated	02015		

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02015	Continued From page 23 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 (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	02015		

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02015	Continued From page 24 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report suspected maltreatment (neglect) of vulnerable adults for 1 of 3 clients (C3) reviewed. C3 experienced a significantly elevated blood pressure, low oxygen saturation, and chest pain. C3 requested to be evaluated by a physician, but the home care provider nurse directed staff not to contact emergency medical services. C3 died of a heart attack. The licensee did not investigate the incident or report it as possible maltreatment. This practice resulted in a level four violation (a violation that results in 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). The findings include:	02015		

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02015	Continued From page 25 C3's medical record was reviewed. C3 was admitted with the diagnosis of chronic obstructive pulmonary disease. C3's service plan, dated December 1, 2017 indicated C3 required supervision assistance with dressing and grooming. C3 required assistance with bathing, managing incontinent products, and medication administration. C3 was independent with transferring and mobility. C3's provider visits were reviewed. C3 was seen by NP-T on November 29, 2017 for a follow up visits. C3 had been to the emergency room the previous day on November 28, 2017 for rectal bleeding. NP-T dictated cause of bleeding was likely related to hemorrhoids. NP-T noted C3's lab work was essentially normal. C3's assessment were reviewed. C3's admission RN assessment was completed December 5, 2017. C3 had an undated 14 day assessment completed. During an interview on January 31, 2018 at 2:55 p.m., HHA-K stated she worked with C3 on December 13, 2017 during the evening shift. C3 coughed a lot and stated he felt awful. C3 had an incontinent bowel movement and HHA-K assisted him in the bathroom. C3 told her he wanted to go the doctor. HHA-K took C3's vitals. HHA-K stated she could not remember his exact blood pressure but the systolic was over 200 and the diastolic was over 125. C3's oxygen saturation was very low, but HHA-K could not remember the number. HHA-K stated she had wrote the vitals on a scratch piece of paper to report them to RN-C, who was on-call. HHA-K stated she reported C3 vitals, his symptoms, and that C3 wanted to go to the doctor. HHA-K stated RN-C refused to send	02015		

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02015	Continued From page 26 C3 to the hospital and told her C3 would be fine, and someone would look at him in the morning. RN-C instructed HHA-K to put oxygen on C3 and give him Tylenol. HHA-K stated she called RN-C four times that night, requesting to send C3 to the hospital. HHA-K stated C3 was white, had a fever, and was shaky. HHA-K stated she was not allowed to send someone to the hospital without the nurse approval or she would be fired. HHA-K stated December 2017, the licensee quit using the electronic medical record and changed to paper charting. HHA-K stated the HHA's were instructed by management they were not allowed to document client status in the client records and therefore was not able to document C3 vitals or status on December 13, 2017. HHA-K stated she was told staff would be fired if went against the nurses instruction and stated she wished she would have sent C3 to hospital despite RN-C's orders. C3's progress notes were reviewed. On December 14, 2017, RN-C wrote C3 complained of chest hurting with breathing and had wheezing in both lungs. C3's oxygen saturation was 92% on oxygen at two liters per minute. RN-C had the float (HHA-H) drive C3 to urgent care. At 8:00 a.m., C3's medical doctor (MD)-P called and instructed C3 to be brought directly to the emergency and not to urgent care. C3's progress note dated December 14, 2017, LPN-F dictated C3 was admitted to the hospital for a heart attack and chronic obstructive pulmonary disease. On December 15, 2017 C3 was transferred to the intensive care unit. C3' death record indicated C3 died on December 21, 2017 and the cause of death was cardiac arrest (heart attack).	02015		

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02015	Continued From page 27 During an interview on February 5, 2018 at 4:20 p.m. FM-Q stated she visited C3 in the hospital. C3 told her he was in pain all night before arriving the hospital. FM-Q asked C3 why he did not report how he was feeling to anyone and stated C3 replied, "I did." During an interview on February 6, 2018 at 9:47 a.m., RN-C stated C3's oxygen saturation was reported by HHA-K as 78% on December 13, 2017. The licensee lacked an internal investigation regarding the incident and there was no record that the licensee reported the incident to the Minnesota Adult Abuse Reporting Center. The licensee policy Vulnerable Adult- Keeping Our Residents Safe dated January 1, 2016, indicated all employees are provided training regarding their obligation and responsibility to report suspected maltreatment to managers, the RN and to the Minnesota Adult Abuse Reporting Center. The manager or RN will investigate the situation and sentinel events will be reported to the direct supervisor and vice president. TIME PERIOD OF CORRECTION: Seven days	02015		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3010 0001 4648 6392

March 7, 2018

Mr. Tim Matros, Administrator
Serenity Living Solutions Of Sebeka
1005 Wells Ave W
Sebeka, MN 56477

RE: Complaint Number HL32493006 and HL32493007

Dear Mr. Matros:

A complaint investigation (#HL32493006 and HL32493007) of the Home Care Provider named above was completed on February 8, 2018, 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
Crow Wing County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services