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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL363462883M
**Compliance #:** HL363464710C

**Date Concluded:** July 10, 2023

**Name, Address, and County of Licensee Investigated:**
In House Home Health
7336 Symphony Street NE
Fridley, MN 55432
Anoka County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Brooke Anderson, RN
Special Investigator

**Finding:** Not Substantiated

**Nature of Investigation:**
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.

**Initial Investigation Allegation(s):**
The facility neglected the resident when the resident sustained bug bites due to a bug infestation in the facility that resulted in infections in both legs requiring hospitalization.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was seen in the emergency room with a leg wound, there was not a preponderance of evidence the wound was a result of a bug infestation in the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of the resident's medical record and facility personnel files, policies, and procedures. In addition, at the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents. There was no evidence of bugs present in the facility or the resident's room at the time of the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, congestive heart failure, and obesity. The resident's customized living tool included assistance with housekeeping, dressing, grooming, and bathing, and indicated the resident had agitation and anxiety.

The resident's medical record indicated the resident reported to facility management a concern about bugs in the facility. The resident reported bugs would bite him at night and fall from the ceiling into his food during the day. The bug bites itched and resulted in the resident scratching his legs.

Hospital records indicated the resident was sent to the emergency room for left leg pain. The resident was diagnosed with cellulitis (bacterial skin infection) and an abscess (a pocket of pus) and placed on two antibiotics. The hospital record indicated the abscess could have been an ongoing abscess that was draining spontaneously.

During an interview, the resident stated the facility had little black bugs crawling everywhere, including on his bed. The resident said he had to go to the emergency room for leg infections from scratching the bug bites and was prescribed antibiotics for the infection. The resident indicated he had informed management about the bugs, but they were no longer a concern and his legs were healing.

During an interview, facility management said the resident admitted to the facility with the leg wound. Facility management staff indicated they were not aware of a bug problem, but recalled the resident requested something to kill the flies in his room. Facility management also recalled the resident would open his window and flies would come in, so they had bought the resident some spray to kill the flies.

During an interview, the facility nurse said she was never informed about a bug concern at the facility. The nurse stated the resident had cellulitis and ongoing edema (swelling) in both of his legs.

During an interview, the resident's case manager recalled the resident reported concerns with black bugs in the facility, bugs in his food, and bites all over his body. The case manager attempted to speak with facility management about the bug concerns but did not receive a response. The case manager indicated the resident had ongoing infections on his legs and other health conditions that could have caused the infections. The case manager was not aware of any documentation or evidence that identified bugs or bug bites were the cause of the infections on the resident's legs.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**"Not Substantiated" means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

**Vulnerable Adult interviewed**: Yes
**Family/Responsible Party interviewed**: No, contact information was not available
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
None.

**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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36346 | A. BUILDING: _____ B. WING _____ | C 06/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IN HOUSE HOME HEALTH | 7336 SYMPHONY STREET NE FRIDLEY, MN 55432 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br>#HL363464710C/#HL363462883M<br><br>On June 22, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license.<br><br>The following correction order is issued/orders are issued for #HL363464710C/#HL363462883M, tag identification 0320. | 0 000 | Assisted Living Provider 144G.<br><br>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS | |

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| 0 000 | Continued From page 1 | 0 000 | USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 320 SS=F | 144G.30 Subdivision 1 Regulatory powers<br><br>(a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.<br>(b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide access to requested necessary resident and staff records to determine compliance to licensure laws and rules.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 320 | | |

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| 0 320 | Continued From page 2<br><br>resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On June 22, 2023, at 8:45 a.m., the Minnesota Department of Health (MDH) investigator entered the facility. Unlicensed personnel (ULP)-D escorted the investigator to the kitchen to be used during the complaint survey process. ULP-D informed the investigator that no registered nurse (RN) or licensed assisted living director (LALD) available to initiate the complaint survey.<br><br>On June 22, 2023, at 9:03 a.m., the investigator emailed the licensee and requested for the following forms completed:<br>- current resident roster;<br>- staff schedule;<br>- grievances;<br>- incident reports;<br>- MAARC reports;<br>- internal investigation documents;<br>- discharge or deceased resident roster; and<br>- hospitalizations;<br><br>On June 26, 2023, at 7:53 a.m., the surveyor emailed LALD-A and requested the following records:<br>- employee files including date of hire, background clearance letter, orientation training, online training, annual training, competency training, 30-day supervisory visit, disciplinary actions;<br>- policies;<br>- resident records including face sheet, progress | 0 320 | | |

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| 0 320 | Continued From page 3<br><br>notes, service delivery record, individual abuse prevention plan, nursing assessments, service plan, and medication administration records;<br><br>Between June 22 - 28, 2023, the investigator was not provided with the above requested documentation, only partial documentation was provided by the LALD-A.<br><br>On June 28, 2023, at 12:55 p.m. the investigator emailed the licensee for the remainder of the requested documents.<br><br>The investigator did not receive the following requested documents:<br>- staff schedule;<br>- grievances;<br>- MAARC reports;<br>- internal investigation documents;<br>- discharge or deceased resident roster; and<br>- hospitalizations;<br>- employee competency records;<br>- employee supervision records;<br>- employee orientation;<br>- resident records including face sheet, progress notes, service delivery record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 320 | | |