MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Auburn Manor

Facility Address:
501 Oak Street North

Facility City:
Chaska

State: Minnesota | **ZIP:** 55318 | **County:** Carver

☒ **Nursing Home**

Report Number:
H5604023, H5604024, and H5604025

Date of Visit:
January 4, 2017

Time of Visit:
7:45 a.m. to 3:45 p.m.

Date Concluded:
April 4, 2017

Investigator's Name and Title:
Jessica Sellner, RN

Allegation(s):
It is alleged that a resident was neglected when the resident wandered into the laundry room and was burned by hot water. The resident was transferred to the hospital. The hospital determined the resident sustained second degree burns to more than 20% of the body. The resident died the following day.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility failed to provide a safe environment and adequate supervision. Facility staff left a locked laundry room door unattended and held open using a magnetic latch, and the resident entered into the laundry room. The resident was found lying in the cement catch basin which collects the hot waste water from the washing machine. The resident sustained second degree burns from hot water and died the next day as a result of the burns.

The facility had four separate hallways of long term care resident rooms which all met at a centrally located nurses station. No units were locked or secured. The laundry room was at the end of one of the resident hallways.

The laundry room had two locked doors approximately six feet apart; one door required a code to open, and the other door required a key. The laundry room door which required a code to open was used when entering the laundry room with dirty laundry. The laundry room door which required a key was used to transport clean laundry out of the laundry room. Laundry room staff did not carry a key to the door as this door was used for exiting the laundry room. When entering the laundry room door through the coded door, there were two washing machines side by side, with two dryers sitting directly beside them. Behind the washing machines was a cement basin in the floor approximately three feet deep, two feet wide, and four

feet long. There was a hose from the washing machines into the basin to drain the hot waste water. On the other side of the dryers, there was a small space used to sort and fold clean laundry. The exit door which required a key to open from the outside was in the clean laundry area for staff to exit.

The resident had severe cognitive impairment and used a wheelchair for mobility, but occasionally stood and walked short distance in an unstable, unsafe manner. The resident was assessed to be a risk for wandering due to his/her cognitive impairment, and regularly entered into other resident rooms. Facility staff were to divert the resident from these wandering behaviors by providing redirection or other diversion interventions if needed.

The resident entered the laundry room when the exit door was completely held open using a magnetic latch on the wall behind the door. No staff were in the laundry room or were able to visualize the laundry room at that time. The resident entered the laundry room door, and left his/her wheelchair in front of the nearest dryer which was approximately 11 feet from the door. The resident proceeded 12 feet without the wheelchair from the corner of the dryer where the wheelchair was left, to the end of the washing machine. The cement basin the resident was found in was located approximately four feet behind the washing machines. A nursing assistant entered the laundry room, saw the resident's empty wheelchair parked in front of the dryer, and heard the resident calling out faintly, "help me." The resident was found lying behind the washing machine in the cement catch basin which was used to drain the hot waste water from the washing machine. In the cement basin, the resident was laying in approximately two to three inches of water. The temperature of the water was estimated to be around 155 degrees. The resident was transfered to the hospital by ambulance and admitted to the burn unit.

The resident sustained second degree burns on the back and buttocks, both ankles, and both feet. The resident died the next day; the death certificate indicated the resident died from complications of thermal injuries and cutaneous hot water exposure.

When interviewed, eight staff members stated the resident wandered throughout the facility in his/her wheelchair on a regular basis. One staff recalled that the resident had entered the laundry room one other time about a year ago, but staff were in the laundry room at the time and the resident was not able to get all the way into the laundry room. According to staff, the laundry room door was held completely open by a magnet and unattended while they were sorting and passing laundry. Housekeeping staff stated using a magnetic latch to hold the laundry room door open during normal working hours was routine practice to make it easier to go in and out of the laundry room often with clean laundry.

The facility had no policy or procedure about locking the laundry room doors. After the incident, the facility removed the magnetic latch which held the laundry room door open and all staff were educated to keep the laundry doors locked when they are not in the room.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

Facility Name: Auburn Manor

Report Number: H5604023, H5604024, and H5604025

☒ 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 practice of the staff was to use a magnetic lock to hold the laundry room door completely open when the laundry room was unattended. Facility administration did not develop policies or procedures to ensure the environment was safe as it relates to the laundry room and to prevent residents from accessing the hazards inside the laundry room.

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:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) 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:

Facility Corrective Action:

The facility took the following corrective action(s):

The facility immediately removed the magnetic latch that held the laundry room door open. All housekeeping and laundry room staff were educated to keep the laundry room doors locked when staff were not able to directly visualize the laundry room doors. When on site at the facility, laundry room doors were locked when unattended by staff. This corrective action removed the immediate risk to other residents, however, harm level citations were issued.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Facility Incident Reports
- [x] Activities Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records [x] Ambulance/Paramedics [x] Death Certificate
- [x] Police Report

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Call Light Audits
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

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: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, 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: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☒ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care

☒ Nursing Services

☒ Dignity/Privacy Issues

☒ Safety 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: Laundry room, Laundry room doors, Catch basin

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Chaska Police Department

Carver County Attorney

Chaska City Attorney

Hennepin County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	R-C 05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	**501 OAK STREET CHASKA, MN 55318**

(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on May 22, 2017, to follow up on deficiencies issued relate to complaint H5604023, H5604024, and H5604025. Auburn Manor is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/10/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Minnesota Department of Health

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	00335	A. BUILDING: _____ B. WING _____	R-C 05/22/2017

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5604023, H5604024, and H5604025. Auburn Manor was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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	245604	A. BUILDING _____ B. WING _____	C 03/13/2017

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F 000	INITIAL COMMENTS *****Revised***** This documend has been revised and replaces the document sent on March 20, 2017. An abbreviated standard survey was conducted to investigate case #H5604023, #H5604024, and #H5604025. As a result, the following deficiency is issued regarding case #H5604023, #H5604024, and #H5604025. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		4/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision and a safe environment to prevent accidents for 1 of 4 residents reviewed, R1. R1 wandered into the laundry room which had the locked door propped open and fell into the washing machine hot water waste. This resulted in actual harm when R1 sustained second degree burns from the hot water and died the next day as a result of the burns. Findings include: R1's Quarterly Minimum Data Set (MDS), dated 10/12/16, indicated the resident had severe cognitive impairment and used a wheelchair for mobility. R1's most recent behavioral Care Area Assessment (CAA) dated 1/13/16, indicated the resident had a diagnoses of Alzheimer's, wandered into other residents room, and was at risk for increased wandering as dementia progressed. R1's Care Plan dated 12/6/16, indicated the resident had behaviors including wandering and directed staff to divert the residents behaviors by providing redirection, offering foods or fluids, conversation, activities, or toileting if needed. R1's Resident Progress Note dated 12/31/16, at 3:20 p.m. indicated nursing was called into the	F 323	It is the policy, and intention, of Auburn Manor in Chaska to be in full compliance with all regulations and requirements of both the Medicaid and Medicare Programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility 's CREDIBLE ALLEGATION OFCOMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. Auburn Manor does ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Contributing factors to the isolated event cited at F 323 involved facility staff propping the clean laundry door open during times of laundry operation. No environmental risks to residents in the laundry department had been previously	

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F 323	Continued From page 2 laundry room because the resident had a fall. The resident was wandering in her wheelchair and went into the laundry room and walked behind the washing machine. R1 fell or sat in the water waste catch basin behind the washing machine. The washing machine was running at the time and hot water waste ran into the water waste catch basin. The progress note indicated a nursing assistant (NA) heard the resident faintly yelling, help me. The NA found R1 in the catch basin and the residents lips were turning blue. R1 had burns on her back, waist, legs, feet, and noted some skin peeling off from her back and feet. The ambulance came and took resident to the hospital. A police report dated 12/31/16, indicated the police were dispatched to the facility for R1 who had wandered into the laundry room and suffered hot water burns on her back and feet when she fell into the waste water catch basin. The report indicated when they arrived R1 was sitting in the wheelchair. The residents skin on her feet had peeled off and they were extremely red, and her back had peeling skin and redness as well. R1 was alert and saying her feet hurt. The report indicated behind the washing machine there was a cement catch basin for waste water to exit and drain from the washing machines which was approximately 2-3 feet wide and uncovered. There were two doors into the laundry room; one was secured by a code, and the other door closest to the end of the hall was locked and required a key to open. The door closest to the end of the hall which required a key to access was believed to be the door R1 used to enter the laundry room. The police report indicated staff stated typically the laundry room doors were locked but staff were transferring laundry in and	F 323	identified as recent as May 18th, 2016 during a routine life safety code survey, and a previous OSHA survey at which time the entire facility, including the laundry department, had been inspected with no safety violations noted in the laundry area. It is the culture of the facility to enhance residents' autonomy and independence creating a homelike environment, while balancing the residents' right to unrestricted movement within the facility (their home) to the extent that we can safely do so while eliminating identified risks and facilitating resident safety. The facility assessed the resident and determined her appropriate placement in the facility, however, as with any human behavior, there is an element of unforeseen unpredictability that led to this accident. The day of the accident, facility staff had correctly assessed and identified the resident's restlessness and implemented identified interventions found in the resident's plan of care. Licensed nursing staff documented the following in the resident's medical record, which supports their appropriate interventions supporting the appropriate response to the resident's exhibited behavior, "She was observed to be up and down multiple times throughout the day. She is assisted by multiple staff each time to walk, to bed, to w/c, to recliner, snack, fluids, toilet and activity with ineffective as she is observed to be up and ambulating after 5-15 minutes. Observed to be mumbling as staff assisting and had some tangling words,	

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F 323	Continued From page 3 out so the laundry room door closest to the end of the hallway was propped open. R1's hospital progress notes dated 12/31/16, and 1/1/17, indicated the resident was admitted to the burn unit with the following burns: Second degree, 18% partial thickness to the back and buttocks, second degree, 1% partial thickness to the right and left ankle, and second degree, 3.5 % partial thickness to the right and left foot. The hospital notes indicated the resident was found lying down in a basin of hot water waste from the washing machine which was approximately 155 degrees. Due to location of burns, it was thought the resident was standing in the basin initially, and fell at some point. When the resident arrived at the emergency room she was crying out in pain but was not communicating as R1 normally would. After discussion with family, the resident was placed on comfort cares and did not wish for any further treatment to be provided. R1 died on 1/1/17, at 3:18 p.m. R1's Death Certificate indicated R1 died on 1/1/17, with the cause of death listed as, "Complications of thermal (scald) injuries," and "Cutaneous hot water exposure." The manner of death was listed as an accident with the injury occurring as the resident, "Fell into the waste water catch basin in the laundry room at her nursing home." The facility investigation dated 1/5/17, indicated nursing assistant (NA)-H entered the laundry room on 12/31/16, at approximately 3:00 p.m. NA-H heard, "help me," in a faint voice and observed a empty wheelchair in front of the dryer. NA-H looked behind the washing machine and observed R1 laying in the basin behind the	F 323	asked if she needed to use bathroom, but stated no, then staff ambulates with her. Observed resident to be tired with ambulation and offered her w/c to sit on and instructed to sit down when she is ready, but becomes agitated and mumbles on words. Re-approached multiple times with different options, then calmed down and sat down to her chair. At one point, she was observed to be looking for her mother early am, and was easily redirected then." As referenced in the Statement of Deficiency, R1 is no longer in the facility as she is deceased. Given the unforeseen unpredictability with any human behavior, the facility has opted to implement the following facility-wide response addressing all residents of the facility since they all have potential to be affected: 1. Immediately following the accident the director of housekeeping/laundry personally instructed each one of her employees to close all doors to the laundry department when no one was in the department. 2. The magnetic door hold open device was immediately removed from the laundry room door by the maintenance director. The director of nursing instructed staff to close the door whenever there was no one in attendance in the laundry department. Immediately following the	

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F 323	Continued From page 4 washing machine in about 2-3 inches of water. NA-H sat the resident up and immediately called for assistance from other staff. According to the facility investigation, NA-L observed R1 wandering in her wheelchair between 2:50 p.m. and 3:00 p.m. When interviewed on 1/4/17, at 12:10 p.m. the administrator stated that the laundry room door at the end of the hall required a key and could be held open by a magnet on the back. The administrator stated laundry staff used the magnet to keep the door open because they were in and out of the laundry room delivering resident laundry. The administrator stated after R1 was found in the laundry room on 12/31/16, the magnet was immediately removed and staff were instructed to keep the door locked unless they were in direct view of the door. When interviewed on 1/4/17, at 12:15 p.m. housekeeping aide (HA)-E stated when laundry was passed the door closest to the end of the hallway was propped open using the magnet on the back of the door. HA-E stated the magnet was removed after R1 was found in the laundry room. HA-E stated about a year ago R1 was wandering in the wheelchair and the laundry room door was propped open and R1 attempted to come into the laundry room but was unable to propel the wheelchair through the door. HA-E stated R1 wandered in her wheelchair often throughout the day. When interviewed on 1/4/17, at 12:45 p.m. HA-F stated when staff were doing laundry the door was held open by the magnet on the back of the door. HA-F stated about a month prior, she was in the laundry room and R1 entered the laundry	F 323	accident, the director of nursing placed temporary signage on both laundry department doors instructing facility staff to keep the doors closed and secured at all times when no one was in the laundry department. 3. The key lock on the door in question has been replaced with a push button code lock facilitating staff's entrance to the laundry room without a key. Not all staff had a key to the keyed lock which may have contributed to the laundry door being left open at times during laundry operation. The push button code lock was ordered on January 2, 2017 and installed on the laundry room door, by the maintenance director, on January 6, 2017, when it arrived at the facility. The magnetic door hold open device was replaced once the door locking device was changed. The magnet is used only when there are staff members in the laundry department. 4. At shift reports, the directors of nursing and housekeeping/laundry will provide verbal instruction on the necessity to keep the laundry room doors secured when no one is in the department. In addition, all facility staff will also receive electronic instruction on the necessity to keep the laundry room doors secured, via the facility's on-line learning program. 5. The facility has installed a custom made metal catch basin cover to lessen the remote possibility of any further like-accident in the laundry department.	

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	245604	A. BUILDING _____ B. WING _____	C 03/13/2017

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F 323	Continued From page 5 room. HA-F stated R1 was easily redirectable and she brought the resident back down the hallway. HA-F stated R1 was often seen wandering in the hallway outside the laundry room, however, she was not aware of any other time the resident entered the laundry room. During observation on 1/4/17, at 1:15 p.m. the facility laundry room was observed with maintence director (MD)-K. The laundry door closest to the exit was closed and required a key to open. The laundry room was on the same level as the residents rooms and was at the end of one of the hallways. The distance from the laundry room door to the front of the dryer was approximately 11 feet, and the distance from the dryer to the basin behind the washing machine was approximately 16 feet. The uncovered cement basin behind the washer was approximately four feet long, and two feet wide and had a hose running into it from the washer. MD-K stated the cement basin was a catch basin for the dirty water from the washing machine. MD-K stated after the waste water was in the cement basin it took approximately 30 seconds for the water to drain, and was at a temperature between 150-155 degrees Fahrenheit. When interviewed on 1/4/17, at 2:30 p.m. NA-H stated on 12/31/16, she went into the laundry room to warm up a blanket for a resident in the dryer and she heard a faint voice say, "help me." NA-H stated at the same time she noticed a empty wheelchair sitting in front of the dryer. NA-H stated she looked behind the washing machine and saw R1 laying in about 2-3 inches of water in the cement catch basin. NA-H stated R1's lips were blue. NA-H assisted R1 to sit up and then called for help from other staff. NA-H	F 323	6. The facility revised the laundry department policies to include the necessity for all doors to the laundry department to be secured when no one is in the department. 7. The facility has implemented the principles of Just Culture (Dekker S. Just Culture: Balancing Safety and Accountability. Burlington, VT: Ashgate Publishing; 2008) in its approach to balancing accountability and resident safety. It is the facility's belief that an analysis of contributing factors leading up to the accident is not about assigning blame but fixing the root cause of factors contributing to the accident. The Just Culture approaches that were implemented in response to this accident included reviewing and revision of facility's policies/procedures/processes, staff (re)education including verbal and electronic communication, of the revised laundry department policies, throughout the facility. 8. Ongoing: Actions initiated to facilitate solutions being sustained include ongoing monitoring of the laundry department doors being secured when no one is in attendance. This monitoring will be the responsibility of the housekeeping/laundry department supervisor. If the laundry department door securement policy is violated, the facility will address the violation utilizing Just Culture Principles to determine the Root Cause of the violation so that appropriate remediation can be	

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F 323	Continued From page 6 stated when she entered the laundry room she used the code to get in, and she could not recall if the other door was propped open. NA-H stated when she found R1 water was not coming out of the hose from the washing machine. When interviewed on 2/10/17, at 1:40 p.m. family member (FM)-D stated after R1 fell on 12/31/16, the resident was in the hospital on the burn unit and was receiving pain medication and comfort measures. FM-D stated R1 was in "extreme pain," from the burns when they first arrived at the hospital. FM-D stated she had spoken to the facility shortly before Christmas and questioned if R1 was still safe at the facility due to her increased behaviors (wandering). FM-D stated the facility assured her the resident was still appropriate to live there and she would be safe. When interviewed on 2/24/17, at 9:10 a.m. housekeeping coordinator (HC)-C stated during laundry operating hours the door was propped open because staff were in and out often hanging up and delivering resident clothes. HC-C stated on 12/31/16, the laundry room door closest to the exit was propped open as it usually was. HC-C stated she went on break at 2:40 p.m. and saw R1 in the hallway at that time. There was one other staff working in laundry on 12/31/16, however, she went down the hallway to clean so was not in the laundry room when R1 entered. HC-C stated she had not seen R1 attempt to enter the laundry room in the past. A facility policy was requested on securing the laundry room but not provided.	F 323	implemented. 9. Ongoing: The housekeeping/laundry department supervisor and the education coordinator will ensure that the training is sufficient to ensure compliance with facility policies, practices, and overall resident safety. 10. Ongoing: The quality assurance committee will review data obtained from the housekeeping/laundry supervisor's aforementioned monitoring as well as safety assessments and facility audits designed to ensure compliance with the laundry department doors being secured when no employee is in attendance in the department. It is the expectation of the quality assurance committee that immediate remediation measures are implemented using the Principles of Just Culture, in the event that the laundry room door is left open when no one is in the department. Data obtained from the quality assurance process, including remedial measures implemented for violations of facility policy, if required, will be reviewed during the quarterly quality assurance meetings to ensure continued compliance.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: *****Revised***** This documend has been revised and replaces the document sent on March 20, 2017. A complaint investigation was conducted to investigate complaint #H5604023, #H5604024, and #H5604025. As a result, the following	2 000		

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2 000	Continued From page 1 correction orders are issued regarding case #H5604023, #H5604024, and #H5604025. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		4/4/17

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2 830	Continued From page 2 Based on observation, interview, and document review, the facility failed to provide adequate supervision and a safe environment to prevent accidents for 1 of 4 residents reviewed, R1. R1 wandered into the laundry room which had the locked door propped open and fell into the washing machine hot water waste. This resulted in actual harm when R1 sustained second degree burns from the hot water and died the next day as a result of the burns. Findings include: R1's Quarterly Minimum Data Set (MDS), dated 10/12/16, indicated the resident had severe cognitive impairment and used a wheelchair for mobility. R1's most recent behavioral Care Area Assessment (CAA) dated 1/13/16, indicated the resident had a diagnoses of Alzheimer's, wandered into other residents room, and was at risk for increased wandering as dementia progressed. R1's Care Plan dated 12/6/16, indicated the resident had behaviors including wandering and directed staff to divert the residents behaviors by providing redirection, offering foods or fluids, conversation, activities, or toileting if needed. R1's Resident Progress Note dated 12/31/16, at 3:20 p.m. indicated nursing was called into the laundry room because the resident had a fall. The resident was wandering in her wheelchair and went into the laundry room and walked behind the washing machine. R1 fell or sat in the water waste catch basin behind the washing machine. The washing machine was running at the time and hot water waste ran into the water	2 830	No POC Required	

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2 830	Continued From page 3 waste catch basin. The progress note indicated a nursing assistant (NA) heard the resident faintly yelling, help me. The NA found R1 in the catch basin and the residents lips were turning blue. R1 had burns on her back, waist, legs, feet, and noted some skin peeling off from her back and feet. The ambulance came and took resident to the hospital. A police report dated 12/31/16, indicated the police were dispatched to the facility for R1 who had wandered into the laundry room and suffered hot water burns on her back and feet when she fell into the waste water catch basin. The report indicated when they arrived R1 was sitting in the wheelchair. The residents skin on her feet had peeled off and they were extremely red, and her back had peeling skin and redness as well. R1 was alert and saying her feet hurt. The report indicated behind the washing machine there was a cement catch basin for waste water to exit and drain from the washing machines which was approximately 2-3 feet wide and uncovered. There were two doors into the laundry room; one was secured by a code, and the other door closest to the end of the hall was locked and required a key to open. The door closest to the end of the hall which required a key to access was believed to be the door R1 used to enter the laundry room. The police report indicated staff stated typically the laundry room doors were locked but staff were transferring laundry in and out so the laundry room door closest to the end of the hallway was propped open. R1's hospital progress notes dated 12/31/16, and 1/1/17, indicated the resident was admitted to the burn unit with the following burns: Second degree, 18% partial thickness to the back and buttocks, second degree, 1% partial thickness to	2 830		

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2 830	Continued From page 4 the right and left ankle, and second degree, 3.5 % partial thickness to the right and left foot. The hospital notes indicated the resident was found lying down in a basin of hot water waste from the washing machine which was approximately 155 degrees. Due to location of burns, it was thought the resident was standing in the basin initially, and fell at some point. When the resident arrived at the emergency room she was crying out in pain but was not communicating as R1 normally would. After discussion with family, the resident was placed on comfort cares and did not wish for any further treatment to be provided. R1 died on 1/1/17, at 3:18 p.m. R1's Death Certificate indicated R1 died on 1/1/17, with the cause of death listed as, "Complications of thermal (scald) injuries," and "Cutaneous hot water exposure." The manner of death was listed as an accident with the injury occurring as the resident, "Fell into the waste water catch basin in the laundry room at her nursing home." The facility investigation dated 1/5/17, indicated nursing assistant (NA)-H entered the laundry room on 12/31/16, at approximately 3:00 p.m. NA-H heard, "help me," in a faint voice and observed a empty wheelchair in front of the dryer. NA-H looked behind the washing machine and observed R1 laying in the basin behind the washing machine in about 2-3 inches of water. NA-H sat the resident up and immediately called for assistance from other staff. According to the facility investigation, NA-L observed R1 wandering in her wheelchair between 2:50 p.m. and 3:00 p.m. When interviewed on 1/4/17, at 12:10 p.m. the administrator stated that the laundry room door at	2 830		

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2 830	Continued From page 5 the end of the hall required a key and could be held open by a magnet on the back. The administrator stated laundry staff used the magnet to keep the door open because they were in and out of the laundry room delivering resident laundry. The administrator stated after R1 was found in the laundry room on 12/31/16, the magnet was immediately removed and staff were instructed to keep the door locked unless they were in direct view of the door. When interviewed on 1/4/17, at 12:15 p.m. housekeeping aide (HA)-E stated when laundry was passed the door closest to the end of the hallway was propped open using the magnet on the back of the door. HA-E stated the magnet was removed after R1 was found in the laundry room. HA-E stated about a year ago R1 was wandering in the wheelchair and the laundry room door was propped open and R1 attempted to come into the laundry room but was unable to propel the wheelchair through the door. HA-E stated R1 wandered in her wheelchair often throughout the day. When interviewed on 1/4/17, at 12:45 p.m. HA-F stated when staff were doing laundry the door was held open by the magnet on the back of the door. HA-F stated about a month prior, she was in the laundry room and R1 entered the laundry room. HA-F stated R1 was easily redirectable and she brought the resident back down the hallway. HA-F stated R1 was often seen wandering in the hallway outside the laundry room, however, she was not aware of any other time the resident entered the laundry room. During observation on 1/4/17, at 1:15 p.m. the facility laundry room was observed with maintence director (MD)-K. The laundry door	2 830		

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2 830	Continued From page 6 closest to the exit was closed and required a key to open. The laundry room was on the same level as the residents rooms and was at the end of one of the hallways. The distance from the laundry room door to the front of the dryer was approximately 11 feet, and the distance from the dryer to the basin behind the washing machine was approximately 16 feet. The uncovered cement basin behind the washer was approximately four feet long, and two feet wide and had a hose running into it from the washer. MD-K stated the cement basin was a catch basin for the dirty water from the washing machine. MD-K stated after the waste water was in the cement basin it took approximately 30 seconds for the water to drain, and was at a temperature between 150-155 degrees Fahrenheit. When interviewed on 1/4/17, at 2:30 p.m. NA-H stated on 12/31/16, she went into the laundry room to warm up a blanket for a resident in the dryer and she heard a faint voice say, "help me." NA-H stated at the same time she noticed a empty wheelchair sitting in front of the dryer. NA-H stated she looked behind the washing machine and saw R1 laying in about 2-3 inches of water in the cement catch basin. NA-H stated R1's lips were blue. NA-H assisted R1 to sit up and then called for help from other staff. NA-H stated when she entered the laundry room she used the code to get in, and she could not recall if the other door was propped open. NA-H stated when she found R1 water was not coming out of the hose from the washing machine. When interviewed on 2/10/17, at 1:40 p.m. family member (FM)-D stated after R1 fell on 12/31/16, the resident was in the hospital on the burn unit and was receiving pain medication and comfort measures. FM-D stated R1 was in "extreme	2 830		

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2 830	Continued From page 7 pain," from the burns when they first arrived at the hospital. FM-D stated she had spoken to the facility shortly before Christmas and questioned if R1 was still safe at the facility due to her increased behaviors (wandering). FM-D stated the facility assured her the resident was still appropriate to live there and she would be safe. When interviewed on 2/24/17, at 9:10 a.m. housekeeping coordinator (HC)-C stated during laundry operating hours the door was propped open because staff were in and out often hanging up and delivering resident clothes. HC-C stated on 12/31/16, the laundry room door closest to the exit was propped open as it usually was. HC-C stated she went on break at 2:40 p.m. and saw R1 in the hallway at that time. There was one other staff working in laundry on 12/31/16, however, she went down the hallway to clean so was not in the laundry room when R1 entered. HC-C stated she had not seen R1 attempt to enter the laundry room in the past. A facility policy was requested on securing the laundry room but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures to ensure a safe environment for all residents. The director of nursing or designee, could conduct random audits of residents who wander and ensure a safe environment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights	21850		4/4/17

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21850	Continued From page 8 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from maltreatment for 1 of 4 residents reviewed, R1. The facility neglected R1 when they failed to provide adequate supervision to keep R1 safe when R1 wandered into the laundry room which had a locked door propped open. This resulted in actual harm for R1 who sustained second degree burns from the washing machine hot water waste and died the following day as a result of the burns. Findings include: R1's Quarterly Minimum Data Set (MDS), dated 10/12/16, indicated the resident had severe cognitive impairment and used a wheelchair for mobility. R1's most recent behavioral Care Area	21850	No POC Required	

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21850	Continued From page 9 Assessment (CAA) dated 1/13/16, indicated the resident had a diagnoses of Alzheimer's, wandered into other residents room, and was at risk for increased wandering as dementia progressed. R1's Care Plan dated 12/6/16, indicated the resident had behaviors including wandering and directed staff to divert the residents behaviors by providing redirection, offering foods or fluids, conversation, activities, or toileting if needed. R1's Resident Progress Note dated 12/31/16, at 3:20 p.m. indicated nursing was called into the laundry room because the resident had a fall. The resident was wandering in her wheelchair and went into the laundry room and walked behind the washing machine. R1 fell or sat in the water waste catch basin behind the washing machine. The washing machine was running at the time and hot water waste ran into the water waste catch basin. The progress note indicated a nursing assistant (NA) heard the resident faintly yelling, help me. The NA found R1 in the catch basin and the residents lips were turning blue. R1 had burns on her back, waist, legs, feet, and noted some skin peeling off from her back and feet. The ambulance came and took resident to the hospital. A police report dated 12/31/16, indicated the police were dispatched to the facility for R1 who had wandered into the laundry room and suffered hot water burns on her back and feet when she fell into the waste water catch basin. The report indicated when they arrived R1 was sitting in the wheelchair. The residents skin on her feet had peeled off and they were extremely red, and her back had peeling skin and redness as well. R1 was alert and saying her feet hurt. The report	21850		

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	00335	A. BUILDING: _____ B. WING _____	C 03/13/2017

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21850	Continued From page 10 indicated behind the washing machine there was a cement catch basin for waste water to exit and drain from the washing machines which was approximately 2-3 feet wide and uncovered. There were two doors into the laundry room; one was secured by a code, and the other door closest to the end of the hall was locked and required a key to open. The door closest to the end of the hall which required a key to access was believed to be the door R1 used to enter the laundry room. The police report indicated staff stated typically the laundry room doors were locked but staff were transferring laundry in and out so the laundry room door closest to the end of the hallway was propped open. R1's hospital progress notes dated 12/31/16, and 1/1/17, indicated the resident was admitted to the burn unit with the following burns: Second degree, 18% partial thickness to the back and buttocks, second degree, 1% partial thickness to the right and left ankle, and second degree, 3.5 % partial thickness to the right and left foot. The hospital notes indicated the resident was found lying down in a basin of hot water waste from the washing machine which was approximately 155 degrees. Due to location of burns, it was thought the resident was standing in the basin initially, and fell at some point. When the resident arrived at the emergency room she was crying out in pain but was not communicating as R1 normally would. After discussion with family, the resident was placed on comfort cares and did not wish for any further treatment to be provided. R1 died on 1/1/17, at 3:18 p.m. R1's Death Certificate indicated R1 died on 1/1/17, with the cause of death listed as, "Complications of thermal (scald) injuries," and "Cutaneous hot water exposure." The manner of	21850		

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21850	Continued From page 11 death was listed as an accident with the injury occurring as the resident, "Fell into the waste water catch basin in the laundry room at her nursing home." The facility investigation dated 1/5/17, indicated nursing assistant (NA)-H entered the laundry room on 12/31/16, at approximately 3:00 p.m. NA-H heard, "help me," in a faint voice and observed a empty wheelchair in front of the dryer. NA-H looked behind the washing machine and observed R1 laying in the basin behind the washing machine in about 2-3 inches of water. NA-H sat the resident up and immediately called for assistance from other staff. According to the facility investigation, NA-L observed R1 wandering in her wheelchair between 2:50 p.m. and 3:00 p.m. When interviewed on 1/4/17, at 12:10 p.m. the administrator stated that the laundry room door at the end of the hall required a key and could be held open by a magnet on the back. The administrator stated laundry staff used the magnet to keep the door open because they were in and out of the laundry room delivering resident laundry. The administrator stated after R1 was found in the laundry room on 12/31/16, the magnet was immediately removed and staff were instructed to keep the door locked unless they were in direct view of the door. When interviewed on 1/4/17, at 12:15 p.m. housekeeping aide (HA)-E stated when laundry was passed the door closest to the end of the hallway was propped open using the magnet on the back of the door. HA-E stated the magnet was removed after R1 was found in the laundry room. HA-E stated about a year ago R1 was wandering in the wheelchair and the laundry room	21850		

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21850	Continued From page 12 door was propped open and R1 attempted to come into the laundry room but was unable to propel the wheelchair through the door. HA-E stated R1 wandered in her wheelchair often throughout the day. When interviewed on 1/4/17, at 12:45 p.m. HA-F stated when staff were doing laundry the door was held open by the magnet on the back of the door. HA-F stated about a month prior, she was in the laundry room and R1 entered the laundry room. HA-F stated R1 was easily redirectable and she brought the resident back down the hallway. HA-F stated R1 was often seen wandering in the hallway outside the laundry room, however, she was not aware of any other time the resident entered the laundry room. During observation on 1/4/17, at 1:15 p.m. the facility laundry room was observed with maintence director (MD)-K. The laundry door closest to the exit was closed and required a key to open. The laundry room was on the same level as the residents rooms and was at the end of one of the hallways. The distance from the laundry room door to the front of the dryer was approximately 11 feet, and the distance from the dryer to the basin behind the washing machine was approximately 16 feet. The uncovered cement basin behind the washer was approximately four feet long, and two feet wide and had a hose running into it from the washer. MD-K stated the cement basin was a catch basin for the dirty water from the washing machine. MD-K stated after the waste water was in the cement basin it took approximately 30 seconds for the water to drain, and was at a temperature between 150-155 degrees Fahrenheit. When interviewed on 1/4/17, at 2:30 p.m. NA-H	21850		

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21850	Continued From page 13 stated on 12/31/16, she went into the laundry room to warm up a blanket for a resident in the dryer and she heard a faint voice say, "help me." NA-H stated at the same time she noticed a empty wheelchair sitting in front of the dryer. NA-H stated she looked behind the washing machine and saw R1 laying in about 2-3 inches of water in the cement catch basin. NA-H stated R1's lips were blue. NA-H assisted R1 to sit up and then called for help from other staff. NA-H stated when she entered the laundry room she used the code to get in, and she could not recall if the other door was propped open. NA-H stated when she found R1 water was not coming out of the hose from the washing machine. When interviewed on 2/10/17, at 1:40 p.m. family member (FM)-D stated after R1 fell on 12/31/16, the resident was in the hospital on the burn unit and was receiving pain medication and comfort measures. FM-D stated R1 was in "extreme pain," from the burns when they first arrived at the hospital. FM-D stated she had spoken to the facility shortly before Christmas and questioned if R1 was still safe at the facility due to her increased behaviors (wandering). FM-D stated the facility assured her the resident was still appropriate to live there and she would be safe. When interviewed on 2/24/17, at 9:10 a.m. housekeeping coordinator (HC)-C stated during laundry operating hours the door was propped open because staff were in and out often hanging up and delivering resident clothes. HC-C stated on 12/31/16, the laundry room door closest to the exit was propped open as it usually was. HC-C stated she went on break at 2:40 p.m. and saw R1 in the hallway at that time. There was one other staff working in laundry on 12/31/16, however, she went down the hallway to clean so	21850		

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21850	Continued From page 14 was not in the laundry room when R1 entered. HC-C stated she had not seen R1 attempt to enter the laundry room in the past. A facility policy was requested on securing the laundry room but not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		