MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Minnesota Heritage House		**Report Number:** HL21049035	**Date of Visit:** June 15 and 16, 2017
Facility Address: 315 12th Street NE Suite B		**Time of Visit:** 8:15 a.m. to 6:30 p.m. 8:15 a.m. to 2:15 p.m.	**Date Concluded:** September 14, 2017
Facility City: Little Falls		**Investigator's Name and Title:** William Nelson, RN, Special Investigator	
State: Minnesota	**ZIP:** 56345	**County:** Morrison	

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that neglect occurred when a fire was intentionally set. The fire at the facility led to the evacuation of more than 30 assisted living residents.

☒ 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 of supervision is substantiated. The facility was aware of the client's history of setting a fire and did not have a plan to address fire-setting behavior.

The client's diagnoses included dementia, diabetes, and hypertension. The client required assistance with bathing, dressing, grooming, skin care, oral care, laundry, medication management and administration and meals. The client smoked cigarettes and the staff were to light the client's cigarette as s/he exited the unit to the patio. Staff were to maintain control of lighters and clients were not allowed to have one in their possession unless approved by the treatment team. The client had a history of setting a fire at a previous nursing home. The facility did not implement any special precautions or additional supervision for the client regarding fire-setting or smoking.

On the night of the fire, the client was in his/her room and another client reported a fire in the south bathroom to staff. The staff member found three towels smoldering in the sink and a client extinguished them by turning the water on. Another client yelled that a fire was in a client room on the north end of the building. The staff member made an announcement to evacuate the building. The fire alarm automatically activated at that time. The fire was reported on the lower level of the building. The nine clients evacuated

the building within an estimated one to two minutes.

The staff member checked each room on the unit and reported no smoke in the room. Then the staff member left the building and looked at the exterior window to the room. White smoke followed by thick black smoke was coming out of the room's exterior window. The smoke detection system automatically called the fire department and the facility administrator called 911.

A staff member reported the client had a history of obtaining lighters at the facility and a staff member reported finding a lighter in the client's pocket while washing the client's clothes after the fire.

The facility had a nursing plan of care, vulnerability assessment, abuse prevention plan, and behavioral care plan for the client. None of the documents addressed fire-setting behavior.

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:

Click Here and Type

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:

Although the facility was aware of the client's history of setting a fire, the facility did not ensure the safety of residents by implementing a plan to address the client's fire-setting behavior.

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.)

Compliance Notes:

Definitions:

The Investigation included the following:

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

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Progress Notes
- ☒ Facility Incident Reports
- ☒ Service Plan

Other pertinent medical records:

☒ Police Report ☒ Other, specify:

Fire department report, State Fire Marshall report

Additional facility records:

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Policies and Procedures
- ☒ Other, specify: Court Records

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: _____

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: ongoing police/fire marshal investigation at time of visit

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

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 state fire marshal

Observations were conducted related to:

☒ 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: Photos of the fire damage in resident room

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Pequot Lakes Police
Pequot Lakes City Attorney
Crow Wing County Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 28, 2017

Administrator
Minnesota Heritage House
920 Southeast Fourth Street
Little Falls, MN 56345

RE: Complaint Number HL21049035 and HL21049036

Dear Administrator:

On October 30, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on June 28, 2017 with orders received by you on July 24, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21049	A. BUILDING: _____ B. WING _____	R-C 10/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

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{0 000}	Initial Comments A licensing order follow-up was completed to follow up on correction orders issued related to complaint HL21049035 and HL21049036. Minnesota Heritage House was found in compliance with state regulations.	{0 000}		

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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, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On June 15, 2017, a complaint investigation was initiated to investigate complaints #HL21049035 and HL21049036. At the time of the survey, there were 75 clients that were receiving services under the comprehensive license. The following correction order is issued in relation to HL21049035.	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)	
0 265 SS=I	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who	0 265		

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0 265	Continued From page 1 receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to receive services which addressed the client's needs, for one of three clients (C1) reviewed. No interventions were developed or implemented to address C1's known history of lighting a fire in another facility. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on May 24, 2016 with diagnoses of dementia, diabetes type II, and depression. C1's nursing plan of care indicated C1 required assistance with bathing, dressing, grooming, skin care, oral care, laundry, housekeeping, medication management and administration, and meals. C1's behavior care plan, dated December 4, 2016, indicated C1 exhibited behaviors of isolating himself in his bedroom, verbalizing suicidal thoughts, and exit	0 265		

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0 265	Continued From page 2	0 265		

seeking. Interventions included encouraging C1 to socialize, using a calm approach, re-direction, and administering medications as ordered. The care plans did not contain any assessment or interventions related to C1's history of lighting a fire in his previous facility.

C1's vulnerability assessment and abuse prevention plan, dated January 3, 2017, indicated C1 was at risk for self-abuse, but did not identify additional interventions to reduce that risk. It also stated C1 was not at risk of abusing other vulnerable adults, but noted C1 had incidents of sexually inappropriate behavior towards staff.

Review of court records indicated that on April 14, 2016, C1 was charged with felony first degree arson. The criminal complaint indicates that C1 was a resident of a nursing home, and that on April 8, 2016, C1 entered another resident's room and lit a fire in that other resident's room. On May 17, 2016, C1 was found not competent to stand trial for the arson charge, and a petition for commitment was entered. On May 31, 2016, C1 was placed on a stay of commitment.

Review of C1's psychological evaluation, conducted on April 20, 2016, to determine C1's competence to stand trial, indicated C1 had severe memory impairment, presented a risk to himself and others due to fire setting, and would benefit from placement in a memory care unit.

Review of C1's behavioral health evaluation, conducted on July 12, 2016, also indicated C1 had been charged with arson due to the incident at his previous facility.

Review of an investigative report from the State Fire Marshal Division indicated a fire occurred on

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0 265	Continued From page 3 June 8, 2017, at the Lower Lodge unit of the housing with services facility known as Heritage House of Pequot Lakes, starting about 7:39 p.m. The investigative report indicated the fire initiated in two different rooms. In a bathroom, there were three partially-burned bath towels that appeared to have been ignited by an open flame. In a client room, the investigation indicated all known accidental causes of fire had been ruled out. That fire originated at the bed, and the cause was most likely an open flame igniting the bedding. The fire was classified as arson based on these findings. Review of the after-fire incident report from the State Fire Marshal Division indicated the cause of the fire was a client starting fires in the bathroom and a bedroom. There was smoke damage throughout the building. The report indicates that if the building had not been promptly evacuated and the fire department called, the results could have been much worse. During an interview on June 15, 2017, at 9:45 a.m., Administrator (AD)-A stated a fire occurred in the Lower Lodge unit. AD-A stated that a fire was started in a common bathroom and in a client's room. More staff were called in, and all clients were evacuated without injury. During an interview on June 17, 2017, at 12:30 p.m., Administrative Assistant(AA)-B stated that after the fire occurred, a staff member doing laundry for clients found a lighter in C1's pocket. During an interview on June 15, 2017, at 4:55 p.m., Licensed Practical Nurse (LPN)-C stated she was working the evening shift on the night of the fire. Home Health Aide (HHA)-D called LPN-C and informed her of smoke in the building. LPN-C	0 265		

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0 265	Continued From page 4 called AD-A, who called 911. LPN-C assisted with evacuation of clients and moved clients to unused rooms in other units. During an interview on June 16, 2017, at 8:45 a.m., HHA-D stated she worked the evening shift the night of the fire. She had started administering medications when a client stated there was a fire in the south bathroom. HHA-D started evacuating the clients from the building. HHA-D saw smoke coming from a client's room. HHA-D was aware C1 had a history of fire setting but did not know anything further about that history. HHA-D stated the practice on the unit was for staff to have a lighter and give it to clients when they wanted to light a cigarette, but then the client's return the lighter, except for one client who was permitted to keep his own lighter. However, staff were aware that C1 was sometimes provided lighters by family members, which then were not controlled. During an interview on June 16, 2017, at 10:05 a.m., Maintenance Staff (MS)-E stated the bathroom where the first fire occurred had no damage, but the bedroom where the second ignition occurred was totally destroyed. The bed was completely burned, the walls were blackened, and there was smoke damage throughout. The entire unit remained unoccupied at that time, until repairs could be completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 265		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who	0 325		

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0 325	Continued From page 5 receives home care services has these rights: (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 one of three clients (C1) reviewed was free from maltreatment (neglect) when no interventions were developed or implemented to address C1's known history of lighting a fire in another facility. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: C1's medical record was reviewed. C1 was admitted to the licensee on May 24, 2016 with diagnoses of dementia, diabetes type II, and depression. C1's nursing plan of care indicated C1 required assistance with bathing, dressing, grooming, skin care, oral care, laundry, housekeeping, medication management and administration, and meals. C1's behavior care plan, dated December 4, 2016, indicated C1 exhibited behaviors of isolating himself in his bedroom, verbalizing suicidal thoughts, and exit seeking. Interventions included encouraging C1 to socialize, using a calm approach, re-direction, and administering medications as ordered. The	0 325		

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0 325	Continued From page 6 care plans did not contain any assessment or interventions related to C1's history of lighting a fire in his previous facility. C1's vulnerability assessment and abuse prevention plan, dated January 3, 2017, indicated C1 was at risk for self-abuse, but did not identify additional interventions to reduce that risk. It also stated C1 was not at risk of abusing other vulnerable adults, but noted C1 had incidents of sexually inappropriate behavior towards staff. Review of court records indicated that on April 14, 2016, C1 was charged with felony first degree arson. The criminal complaint indicates that C1 was a resident of a nursing home, and that on April 8, 2016, C1 entered another resident's room and lit a fire in that other resident's room. On May 17, 2016, C1 was found not competent to stand trial for the arson charge, and a petition for commitment was entered. On May 31, 2016, C1 was placed on a stay of commitment. Review of C1's psychological evaluation, conducted on April 20, 2016, to determine C1's competence to stand trial, indicated C1 had severe memory impairment, presented a risk to himself and others due to fire setting, and would benefit from placement in a memory care unit. Review of C1's behavioral health evaluation, conducted on July 12, 2016, also indicated C1 had been charged with arson due to the incident at his previous facility. Review of an investigative report from the State Fire Marshal Division indicated a fire occurred on June 8, 2017, at the Lower Lodge unit of the housing with services facility known as Heritage House of Pequot Lakes, starting about 7:39 p.m.	0 325		

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0 325	Continued From page 7 The investigative report indicated the fire initiated in two different rooms. In a bathroom, there were three partially-burned bath towels that appeared to have been ignited by an open flame. In a client room, the investigation indicated all known accidental causes of fire had been ruled out. That fire originated at the bed, and the cause was most likely an open flame igniting the bedding. The fire was classified as arson based on these findings. Review of the after-fire incident report from the State Fire Marshal Division indicated the cause of the fire was a client starting fires in the bathroom and a bedroom. There was smoke damage throughout the building. The report indicates that if the building had not been promptly evacuated and the fire department called, the results could have been much worse. During an interview on June 15, 2017, at 9:45 a.m., Administrator (AD)-A stated a fire occurred in the Lower Lodge unit. AD-A stated that a fire was started in a common bathroom and in a client's room. More staff were called in, and all clients were evacuated without injury. During an interview on June 17, 2017, at 12:30 p.m., Administrative Assistant(AA)-B stated that after the fire occurred, a staff member doing laundry for clients found a lighter in C1's pocket. During an interview on June 15, 2017, at 4:55 p.m., Licensed Practical Nurse (LPN)-C stated she was working the evening shift on the night of the fire. Home Health Aide (HHA)-D called LPN-C and informed her of smoke in the building. LPN-C called AD-A, who called 911. LPN-C assisted with the evacuation of clients and moved clients to unused rooms in other units.	0 325		

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MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 325	Continued From page 8 During an interview on June 16, 2017, at 8:45 a.m., HHA-D stated she worked the evening shift the night of the fire. She had started administering medications when a client stated there was a fire in the south bathroom. HHA-D started evacuating the clients from the building. HHA-D saw smoke coming from a client's room. HHA-D was aware C1 had a history of fire setting but did not know anything further about that history. HHA-D stated the practice on the unit was for staff to have a lighter and give it to clients when they wanted to light a cigarette, but then the client's return the lighter, except for one client who was permitted to keep his own lighter. However, staff were aware that C1 was sometimes provided lighters by family members, which then were not controlled. During an interview on June 16, 2017, at 10:05 a.m., Maintenance Staff (MS)-E stated the bathroom where the first fire occurred had no damage, but the bedroom where the second ignition occurred was totally destroyed. The bed was completely burned, the walls were blackened, and there was smoke damage throughout. The entire unit remained unoccupied at that time, until repairs could be completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		