MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Golden LivingCenter Meadow Lane	H5313031	October 21, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
2209 Utah Avenue	10:45 a.m.-3:30 p.m.	January 30, 2017
Facility City:	**Investigator's Name and Title:**	
Benson	Jill Hagen, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56215	Swift

☒ **Nursing Home**

Allegation(s):
It is alleged a resident was neglected when staff failed to adequately supervise a resident who needed assistance with meals. The resident sustained a burn with blisters which required medical attention.

- ☒ 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 staff left the resident unsupervised. The resident spilled hot soup on his/her lap causing first, second, and third degree burns to the resident's upper left thigh.

The resident's diagnoses included Alzheimer's disease with delusional disorder. The resident had a history of reaching out for food and spilling liquids. At times, the resident was capable of independently eating finger foods with staff assistance. The resident had limited vision and often did not wear his/her glasses. The resident required a wheel chair for mobility and the assistance from one to two staff to complete all activities of daily living.

During an evening meal, staff served the resident a bowl of hot soup. Staff left the meal in front of the resident at the dining room table. The resident grabbed the bowl and the soup spilled on the resident's upper legs. A nurse immediately assessed the resident's abdomen and observed no redness. When the resident finished his/her meal, the resident was brought back to the resident's room so staff could assess the resident's skin where the soup made contact on the upper legs, but the resident declined to remove his/her pants. Three-and-one-half hours later, the resident allowed staff to assess his/her legs. When staff removed the resident's pants, staff observed a 9 centimeter (cm) by 7 cm red draining wound with the top layer of peeling skin to the resident's upper left thigh. A nurse applied an antibiotic ointment and covered the wound with a dry dressing. The resident was scheduled to see a doctor the following morning.

At the time of the incident, the resident's care guide for eating instruction directed staff to provide supervision with limited assistance using a lip plate or raised edge plate. The care guide instructed staff to offer the resident assistance and/or cues with meals. Interviews were conducted with staff members working the evening the resident was burned; none of the staff could remember serving the resident the meal. Staff indicated the resident was not always supervised at meal times, frequently reached for food in front of him/her, and would often spilled liquids on him/her. A nurse indicated the resident needed constant staff supervision to assist with meals. Some staff provided constant supervision for the resident with meals, while other staff might leave to assist other residents or continue to distribute meals to other residents. The nurse indicated the facility should have been aware the resident was a potential risk for burns with hot items.

Review of the resident's medical record established the resident was diagnosed with first, second, and third degree burns on the resident's upper left thigh measuring 20 cm by 20 cm. To treat the serious burns, the resident required Tylenol for pain before daily dressing changes including application of Silvadene cream. Subsequent doctor visits were required to monitor the healing.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility failed to care plan the resident's risk for burns when served hot liquids and provide supervision when meals were served. The facility failed to consistently communicate through the development of the resident's care plan to continually supervise the resident while eating.

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 Met
The facility was found to be in compliance with Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B). No deficiencies were issued.

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter

4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

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):

Prior to the on-site investigation the facility assessed and developed the resident's care plan. The care plan included staff to provide constant supervision to the resident during meals. The facility reviewed all the care plans of all resident's that required assistance with their meals. Observations confirmed staff served the residents when they were able to stay with the resident and immediately assisted the residents with meals. Covers and/or spill proof lids were placed on containers with hot liquids when served to the resident. All staff were provided training on the eating and supervision requirements for the residents. Interviews with staff established they had been provided the required training. Management staff completed audits and monitoring for staff compliance.

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] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility In-service Records
- [x] Facility Policies and Procedures
- [x] Other, specify: Audits completed to ensure staff compliance with the resident' care plan

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 complainant(s) ○ Yes ○ No ◉ N/A

Specify: Facility self-report

If unable to contact complainant, attempts were made on:

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

Interview with family: ○ Yes ◉ No ○ N/A Specify: Message left for family to contact investigator

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Unable to interview due to level of dementia

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: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: None identified

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:

- [x] Nursing Services
- [x] Safety Issues
- [x] Meals
- [x] Facility Tour
- [x] Injury
- [x] Other: Resident's wound

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: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Benson Police Department

Swift County Attorney

Benson City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	**2209 UTAH AVENUE BENSON, MN 56215**

(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 An abbreviated standard survey was conducted to investigate case #H5313031. Golden Livingcenter Meadow Lane 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 you acknowledge receipt of the electronic documents.	F 000		

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

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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	00930	A. BUILDING: _____ B. WING _____	C 11/15/2016

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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 complaint investigation was conducted to investigate complaint #H5313031. As a result the following correction order is issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of	2 000		

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2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights 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, document review, and interview, the facility failed to provide adequate supervision during a meal to ensure a resident's safety for 1 of 1 (R1) records reviewed for injury. When staff left R1 unsupervised with hot soup, the resident spilled the soup on his lap causing first, second, and third degree burns to R1's upper left thigh. Findings include: Review of the facility's policy and procedure titled Vulnerable Adult Maltreatment Plan with a	21850		

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21850	Continued From page 2 revision date of 10/2011, defined neglect as the facility's failure or omission to provide a resident with care or services needed to obtain or maintain the resident ' s health and safety to avoid physical harm and mental anguish. The necessary care provided to the residents included staff supervision. On 10/21/2016, from 12:05 p.m. through 12:45 p.m. observations was made of R1 being assisted by staff to eat a noon meal. R1 often attempted to reach out for food items in front of him and required staff redirection. Staff assisted R1 to eat the entire meal. Review of R1's medical record established R1's diagnoses included Alzheimer ' s disease. R1 required others to make all of his decisions. R1's plan of care for nutrition risk with an initiate date of 2/9/2016, directed staff to use a lip or raised edge plate and monitor R1 ' s meal consumption. Review of R1's care guide not dated but provided by the facility to direct R1's care by staff directed staff to provide R1 with a regular diet, provide R1 with staff supervision and limited assistance with meals. Staff should offer assistance/cues to R1 with meals. R1 required a wheelchair for all mobility and extensive staff assistance to complete all activities of daily living. R1 frequently refused staff assistance by hitting out. Staff approached R1 later to complete his cares. The care guide failed to address the level of staff supervision R1 required during a meal. Review of the facility's incident report dated 8/9/2016, at 10:15 p.m. revealed R1 spilt tomato soup on himself during the evening meal. Staff placed food in front of R1 where he could reach the food before staff was available to supervise R1. When observed by staff R1 had a	21850		

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21850	Continued From page 3 9-centimeter (cm) by 7 cm red weeping burn with the top layer of skin peeled away to the left upper thigh. Staff applied triple antibiotic ointment and a dry dressing. Staff notified administration of the burn. A progress note dated 8/10/2016, at 2:51 p.m. revealed R1 had a clinic visit with his practitioner and a wound nurse at 10:15 a.m. that morning. R1 returned to the facility with physician orders to keep the left thigh blisters intact to allow for absorption of the fluid, generously apply Silvadene cream used to treat severe burns, cover the burn with a non-stick dressing, and an large padded or dry dressing. The progress note on 8/10/2016, at 3:18 p.m. revealed the burn to R1's left upper thigh measured 20 cm by 8 cm. A physician's progress note dated 8/18/2016, not timed revealed R1 left upper leg wound measured 20 cm by 20 cm with areas of variable depth. The wound consisted of about 20 % third degree burns, with several areas of deep second-degree burns, and about 50 % of the surface was first-degree burns. The note indicated the wound was making good progress toward healing. Interview with RN-A on 11/10/2016, at 10:23 a.m. established on 8/9/2016, around 6:00 p.m. staff brought R1 the meal tray at the dining room table and left R1 with the meal in front of him. R1 grabbed the bowl of soup and spilled the hot soup in his lap. R1 had a tendency to reach for items on his tray and often tipped over liquids due to R1's poor eyesight. About one-half of the staff stayed with R1 to assist with the meal. The facility staff should have known R1's potential risk especially with hot items and care planned for constant supervision with meals.	21850		

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21850	Continued From page 4 Interview with nursing assistant (NA)-B on 11/10/2016, at 10:55 a.m. established there was inconsistent communication with staff on the amount of supervision R1 required during meals. With orientation, staff verbally informed NA-B not to serve R1 hot items without supervision. NA-B said those safely measures were not part of R1's care plan. Interview with NA-C on 11/10/2016, at 3:17 p.m. revealed R1 often reached out for food placed in front of him. NA-C said there was no communication to remind staff to keep hot food out of R1's reach. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME FOR CORRECTION: Twenty-one (21) days.	21850		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00930 Y1	A. Building B. Wing Y2	1/24/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 12/13/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: 80OB12

STATE FORM: REVISIT REPORT (11/06)