DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2019

Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007

Re: Reinspection Results - Complaint Number H5338029

Dear Administrator:

On December 24, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 7, 2018. At this time these correction orders were found corrected.

Please note, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

January 4, 2019

Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007

RE: Project Number H5338029

Dear Administrator:

On December 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on November 21, 2018. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

On December 7, 2018, an abbreviated standard survey was completed by the Minnesota Department of Health, Office of Health Facility Complaints, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 21, 2019. (42 CFR 488.417 (b))

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal

rights.

Please note, 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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not

alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction. If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federalregulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
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	245338	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE ALBERT LEA, MN 56007**

(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 unannounced survey was conducted on 12/7/18 to investigate complaint #H5338029. St Johns Lutheran Community was NOT found in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. #H5338029 was substantiated at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to minimize the risk of injury for 1 of 3 residents (R1) who was reviewed	F 689	F689 □ 1.) Corrective action for the alleged deficient practice: Resident R1□s plan of care was updated to state Cool any hot	1/11/19

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

Electronically Signed | 01/10/2019

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 689	Continued From page 1 for accidents, who had a history of difficulty managing food and liquids during eating activities. R1 sustained actual harm when she received a burn to the sternum requiring a physician visit and referral to a burn clinic. Findings include: R1's current diagnosis listing included: anxiety disorder, major depressive disorder, muscle weakness, history of falls with fractures, syncopal episodes (fainting), osteoporosis and chronic kidney disease. Review of the current quarterly minimum data set (MDS) assessment dated 9/25/18, identified R1 as having a brief interview for mental status (BIMS) score of "13" (meaning cognitively intact). R1 understands and is understood. R1 eats independently with set up help. No impairments in upper and lower extremities. A quarterly nutritional assessment dated 9/25/18, identified R1 as being independent with eating. R1 does not utilize adaptive devices during eating and has no skin concerns. A quarterly skin assessment dated 9/24/18, identified R1 with no skin impairments. R1's skin is assessed during daily cares and during weekly bathing. Review of the current plan of care, identifies R1 as having an alteration in thought process related to syncope/collapse and impaired glucose. The care plan further indicated: R1 has good memory recall, understands and is understood. R1 is independent with eating with assistance of tray set up and opening condiments/containers. R1	F 689	beverages before serving. Use a lid for cup. Use a lip plate for meals. Eat meals in the solarium/assisted table. Never leave resident unattended with meal or hot liquids. Inform family and friends of her need for assistance and not to serve her hot coffee. The care plan was also updated to state that she requires total tray set up, assist of 1 to start/finish, but can feed herself part of her meal with cues/encouragement and adaptive silverware. Education was provided to staff during report at change of shift x 3 days (12/7/18-12/10/18), and the nursing newsletter with paycheck distribution on 12/14/18 and 1/11/18, reminding staff that Residents that require assistance with meals, this includes observation and cueing needs, should never be left alone with their meal, as they are at risk without assistance, and Do not leave residents, who require assistance with eating and drinking, unsupervised with any hot liquids. 2.) Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents who require assistance with eating, including cueing and observation, have the potential to be affected. 1.) Education was provided to staff during report at change of shift x 3 days (12/7/18 -12/10/18), and the nursing newsletter with paycheck distribution on 12/14/18 and 1/11/18, reminding staff that Residents that require assistance with meals, this includes observation and cueing needs, should never be left alone with their meal, as they are at risk without	

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F 689	Continued From page 2 has impairment with vision and physical mobility, related to weakness and impaired safety awareness. (The care plan did not include supervision while handling hot coffee or requiring assistance with eating). A current nursing assistant (NA) care plan identified R1 as having impaired vision, and indicated the resident usually understands and is understood. Additionally, the NA care plan identified R1 as independent with eating with assist to set up tray, and requires staff supervision for signs of choking. (The NA care plan did not include supervision while handling hot coffee or requiring assistance with eating). Review of the progress notes dated 10/6/18, at 10:18 a.m. indicated dietary staff had reported R1 as having more difficulty feeding herself. The note indicated options were discussed and a lip plate was implemented. Review of the nursing progress notes for 11/21/18 did not reveal any mention of a coffee spill or burn injury to R1's shoulder or chest, nor any evidence of a physical assessment being completed by a licensed nurse after R1 spilled coffee on herself. The notes did not contain evidence of any other monitoirng or skin checks being completed over the next 24 hours to monitor the extent of the injury sustained during this event. Review of R1's current care plan did not reveal any changes were made to reflect R1's need for help or increased supervision with hot beverages. A progress note dated 11/23/18, at 5:56 a.m. indicated R1 was noted to have an open blistered area from the upper chest to between the breast. R1 also was noted to have an intact blister on the abdomen that measured 4 cm (centimeters)	F 689	assistance, and Do not leave residents, who require assistance with eating and drinking, unsupervised with any hot liquids. 2.) A policy and procedure was implemented in regards to burns, and includes updating the plan of care to reflect changes implemented to prevent further burns. Copies of this were available for nurses to pick up with their paychecks on 1/11/18. 3.) Nurse Managers were given an auditing form to complete that looked at which residents required assistance with their meals, including cueing and observation, and if their plan of care reflected this. If not, the plan of care was to be updated. The Nurse Managers will complete this by January 11, 2019. 3.) Measures/Systematic changes put in place to assure the alleged deficient practice does not re-occur: Nurse Managers will complete monthly audits on residents who require assistance with eating, and verify that their plan of care reflects this. A burn policy/procedure was implemented. Education was provided to staff reminding them that residents who require assistance with meals, including observation and cueing, should never be left alone with their meal, as they are at risk without assistance; and not to leave residents, who require assistance with eating and drinking, unsupervised with any hot liquids. 4.) Corrective actions will be monitored to ensure the alleged deficient practice will not re-occur: Continued audits by Nurse Managers of residents who require assistance with eating, and the adequacy	

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F 689	Continued From page 3 wide. The note indicated R1 had reported to staff she spilled hot coffee on herself while she was at home with her family celebrating Thanksgiving on 11/22/18. A subsequent progress note entry at 10:32 a.m. on 11/23/18, indicated R1 had been found during the night with pink itchy skin on her chest. The note indicated R1 had told staff she'd spilled coffee on herself. Blistering was reported by the night staff but had subsided by the time of this note. Staff spoke with F-B who indicated the burn had happened at the facility prior to her outing on 11/22/18, and he was already aware of the burn the previous day, when he came to the facility to visit and noted R1 holding a washcloth on her shoulder at the time of his visit. A MD/NP Fax Communication Form, dated 11/23/18 indicated R1 had a burned and blistered area on her chest from spilling hot coffee on herself "2 days ago [11/21/18]" and the blistered area was 8 centimeters by 18 centimeters. The fax was returned signed by the provider on 11/26/18, with orders to clean the affected area twice daily and apply Vaseline. A progress note entry dated 11/24/18, at 8:47 a.m. indicated R1's chest and abdomen area were pink in color with peeling skin. The note further indicated the resident had been picking a reddenend area on the right side of her chin as well and included, "Will continue to monitor." A progress note at 8:50 a.m. described R1's chest and abdomen to be pink in color and the skin to be peeling, and described a 1 1/2 cm by 2 cm reddened area was noted on the right side of the resident's chin. The note indicated R1 believed this was caused by the hot coffee she'd spilled and included, "Waiting for an order from the physician for treatment to the burned skin areas	F 689	of their plans of care. Any inconsistencies will be corrected immediately and education provided. The DON or designee will report the findings of the audits to the QA committee for recommendations to ensure ongoing compliance.	

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and will continue to monitor."

A nursing progress note dated 11/26/18, at 4:15 p.m. indicated a physician order had been received to apply Vaseline to R1's burned skin areas until healed.

A progress note dated 11/28/18, at 10:09 a.m. included, "[R1's] chest skin remains intact but is greenish in color underneath the skin. Reported to certified nurse practitioner (CNP)-A and obtained an order for silvadene cream twice a day (bid)." A progress note dated 11/29/18, at 10:09 a.m. indicated R1's burns measured 7cm wide at the sternal region and 16 cm in length from sternum to the abdominal region. The note described the burn as having "yellowish and green pockets of exudate noted throughout" the lesion/burn.

A progress note dated 11/28/18 at 11:04 a.m., indicated a physician's order had been received for R1 to continue with silvadene cream bid (twice a day) for 2 weeks. At that time, the note also indicated R1 had been examined by CNP-A who had indicated R1's lesion/burn was showing early signs of healing.

A progress note dated 11/30/18, at 2:09 p.m. indicated an appointment had been made for R1 to be seen at urgent care on 12/1/18, to assess her burns.

A progress note dated 12/1/18, at 2:20 p.m. indicated R1 had been taken to urgent care by F-A and the facility staff received a call from CNP-B from urgent care at that time. CNP-B reported to the facility staff he had filed a complaint to the State Agency related to R1's

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burns. The note indicated CNP-B had told facility staff F-A reported to him R1's burns had happened at the health care facility where she resided. A referral was made by CNP-B for R1 to be seen on 12/3/18, at Regions Burn Center for evaluation and treatment. Prior to the appointment, orders were to continue silvadene cream treatment to the burns.

A progress note dated 12/3/18, indicated R1 returned from an appointment at Regions Burn Clinic with orders to continue with the silvadene cream treatment.

During observation of the breakfast meal on 12/7/18, at 8:54 a.m. R1 was sitting in the first floor north assisted dining room. Nursing assistant (NA)-A was observed to assist R1 with meal preparation and fed R1 bites of egg from a spoon. R1 was further observed to independently grab a piece of toast from her plate, and eat it. During the meal, NA-A handed R1 a glass of milk which R1 consumed, and R1 set the glass back down on the table independently.

During observation of R1's chest burn treatment on 12/7/18, at 10:05 a.m. RN-B obtained dressing change supplies, washed hands, applied gloves, and removed gauze wrapping to R1's chest area. The area was cleansed with saline and gauze, and measurements obtained. RN-B identified the red and superficial open chaffed chest area as a burn measuring 8 cm across by 18 cm down. RN-B identified two spearate areas of yellowish soft scab like areas mid sternum measuring 2 cm by 3 cm, and 1 cm by 1 cm to the lower sternum. Silver sulfadiazine 1% premoistened gauze was applied, nonstick pads were placed over the area, and the area was wrapped with kerlix. RN-B

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stated identified the area was healing with no signs and symptoms of infection.

A physician visit progress note dated 12/1/18, during an urgent care visit. CNP-B indicated R1 was seen at urgent care with a burn to the chest. R1 was examined and observed to have a burn in the area of the sternum from the sternoclavicular notch to just below the xiphoid, with some burns on the abdomen bilaterally. The area was described as having honey crusted skin over the heart area with no swelling around the edges of the burn. The note indicated no infection was identified but indicated a referral had been made to Regions Burn Center for a consult for treatment. Orders to continue silvadene cream. CNP-B indicated R1's family (F)-B reported R1 often was unable to feed herself, and the nursing home staff gave her hot coffee on 2 occasions (a few days before Thanksgiving and the day of Thanksgiving) which she spilled on her chest. F-B indicated he had contacted the nursing home where R1 resides to inform them he had filed a vulnerable adult (VA) complaint. The progress note further indicated the facility informed him R1 had spilled hot coffee while out on an outing with family over Thanksgiving. Due to the information received from the family, CNP-B indicated he was required to file a vulnerable adult to the State related to potential neglect.

During interview on 12/7/18, at 9:18 a.m. nursing assistant (NA)-B stated R1 was shaky at times, had poor vision, and had a tendency to spill food and fluids. NA-B further stated staff had needed to guide and assist R1 with food and fluids for the last couple of months.

During a subsequent interview 12/7/18, at 9:50

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a.m. NA-B stated staff can ususally guide beverages to R1's lips and let go, but sometimes R1 will grab the beverage before staff are ready to help her. NA-B stated R1's ability and shakiness varied daily. NA-B was not aware of R1 spilling coffee other than when she had went out with family on Thanksgiving, and further stated coffee wasn't allowed for R1 unless she had assistance to drink it. NA-B also stated R1 required no special equipment to drink beverages.

During interview on 12/7/18, at 9:57 a.m. registered nurse (RN)-B stated R1 had spilled coffee in the afternoon at the facility a week or so ago and had obtained a superficial pink area. RN-B stated since that time R1 had received increased supervision of her meals and coffee. RN-B stated the burn to R1's chest area was identified by night shift staff the morning of 11/23/18, and had been brought to her attention. RN-B stated she had assessed the area to R1's chest at that time but it was not red, weeping or painful. RN-B said the area had appeared as if the resident had been rubbing it. RN-B stated she had notified the physician per fax at that time, but wasn't sure when the burn had occurred.

During a telephone interview with F-A on 12/7/18 at 10:00 a.m., F-A stated he was aware of R1's burns. F-A stated he did not think R1's burns occurred on Thanksgiving while out with family. F-A stated he had thought F-B had told him R1 may have burned herself at the nursing home, but could not verify. F-A further stated F-B may be able to give more information on when R1's burn occured and where.

During interview on12/7/18, at 10:21 a.m. NA-A

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	245338	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE ALBERT LEA, MN 56007**

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stated R1 had required more assistance with meals in the last month or so due to her shakiness. NA-A further stated R1 required help to guide or prompt her to eat and get the glass to her mouth. NA-A stated R1 "can have coffee, but needs assistance and staff must stay with her when drinking it."

During observation and interview on 12/7/18, at 12:45 p.m. with the certified dietary manager (CDM), the temperature of the facility coffee was noted to be 188.6 degrees Fahrenheit when dispensed directly from the coffee machine into a carafe the facility would typically use for distribution. The CDM stated the carafes were insulated to help keep hot liquids warm for about 4-6 hours, however, the facility often ended up reheating coffee for residents.

During a telephone interview on 12/7/18 at 12:52 p.m., CNP-B stated R1 had been seen at Urgent Care on 12/1/18, related to coffee burns on her chest area. CNP-B stated F-A informed him R1 was not getting the assistance she needed and had been spilling hot coffee on herself causing skin burns. CNP-B further stated F-B informed him the nursing home staff had not been doing anything about the burn other than a vaseline application treatment and that R1 had not been examined by a medical provider. CNP -B stated he felt R1's burns to the chest area were significant enough for further treatment and intervention to include a referral to Regions Burn Clinic.

During an interview with the director of nursing (DON) on 12/7/18, at 11:01 a.m. the DON stated she'd become aware of R1's burn concerns when she'd recieved a call from CNP-B from Urgent

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Care on 12/1/18. The DON stated that she had completed an investigation related to the burns. The DON stated through staff interview it was determined R1 had spilled hot coffee on herself at the facility on 11/21/18 and had obtained a small red area on the right shoulder that subsided a couple hours later. The DON further stated that through interview it was determined F-B had reported to two staff the resident had spilled hot coffee on herself while with family on 11/22/18 when they were celebrating Thanksgiving. The DON stated she assumed interventions had been put in place after R1 spilled hot coffee on herself on 11/21/18, but confirmed no changes had been made with the resident's plan of care.

RN-A stated during interview on 12/7/18, at 11:44 a.m. R1 had spilled coffee on herself about 3 months ago (9/18), but had not gotten burned. RN-A stated at that time she'd felt it was an isolated situation because it was a visitor that gave her the coffee and not one of the staff members. RN-A further stated she was aware of R1's reddened right shoulder on 11/21/18, after R1 had spilled hot coffee on herself. RN-A stated the staff had been instructed not to leave R1 alone when given hot coffee, however, this intervention had not been added to the plan of care for all staff to be aware of. RN-A further stated R1 had recently experienced a decline in condition and required increased supervision and assistance with eating. RN-A also said R1's assessment period was next week and the plan of care would be updated at that time.

During interview on 12/7/18, at 12:05 p.m. licensed practical nurse (LPN)-A stated F-A told her R1 had spilled coffee when out with family for Thanksgiving. LPN-A further stated she was not

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aware of any interventions or precautions related to R1 and coffee. LPN-A stated, "If [R1] wants coffee, she can have it."

During interview on 12/7/18, at 12:10 p.m. NA-C stated R1 had gone out with family on Thanksgiving day 11/22/18. NA-C stated after R1 had returned she'd assisted R1 with evening cares, and had notified the nurse her chest area and under breasts was rashy in appearance, however, could not recall R1's clothing being stained with coffee upon her return to the facility.

During interview on 12/7/18, at 3:40 p.m. NA-D stated she had given R1 a cup of coffee from the snack cart on 11/21/18. NA-D stated she had filled a styrofoam cup about 1/4 full of coffee. NA-D stated almost immediately R1 had put her call light on because she'd spilled the coffee. NA-D said she'd answered the light, and had noted the coffee had been spilled on R1's shoulder. NA-D stated she'd looked at R1's skin under her shirt, noticed the area was pink, obtained a cold wash cloth, and had notified the nurse. NA-D stated she had never known the resident to spill coffee but was aware that she frequntly spilled other liquids indicating that was why only a 1/4 cup of coffee had been provided to the resident. NA-D stated, "Now staff need to sit and assist [R1] to drink coffee."

A telephone call was placed to F-B on 12/7/18, at 9:00 a.m. and 12/17/18, at 2:30 p.m., but there was no return call.

Electronically Delivered

January 4, 2019

Administrator
St. Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders - Complaint Number H5338029

Dear Administrator:

A complaint investigation was completed on December 7, 2018. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and 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/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00138	A. BUILDING: _____ B. WING _____	C 12/07/2018

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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 on 12/7/18, to investigate complaint #H5338029. As a result the following orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of	2 000		

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2 000	Continued From page 1 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		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to minimize the risk of injury for 1 of 3 residents (R1) who was reviewed for accidents, who had a history of difficulty managing food and liquids during eating activities. R1 sustained actual harm when she received a burn to the sternum requiring a physician visit and referral to a burn clinic. Findings include:	2 835	Corrected	1/11/19

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2 835	Continued From page 2 R1's current diagnosis listing included: anxiety disorder, major depressive disorder, muscle weakness, history of falls with fractures, syncopal episodes (fainting), osteoporosis and chronic kidney disease. Review of the current quarterly minimum data set (MDS) assessment dated 9/25/18, identified R1 as having a brief interview for mental status (BIMS) score of "13" (meaning cognitively intact). R1 understands and is understood. R1 eats independently with set up help. No impairments in upper and lower extremities. A quarterly nutritional assessment dated 9/25/18, identified R1 as being independent with eating. R1 does not utilize adaptive devices during eating and has no skin concerns. A quarterly skin assessment dated 9/24/18, identified R1 with no skin impairments. R1's skin is assessed during daily cares and during weekly bathing. Review of the current plan of care, identifies R1 as having an alteration in thought process related to syncope/collapse and impaired glucose. The care plan further indicated: R1 has good memory recall, understands and is understood. R1 is independent with eating with assistance of tray set up and opening condiments/containers. R1 has impairment with vision and physical mobility, related to weakness and impaired safety awareness. (The care plan did not include supervision while handling hot coffee or requiring assistance with eating). A current nursing assistant (NA) care plan identified R1 as having impaired vision, and indicated the resident usually understands and is understood. Additionally, the NA care plan identified R1 as independent with	2 835		

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2 835	Continued From page 3	2 835		

eating with assist to set up tray, and requires staff supervision for signs of choking. (The NA care plan did not include supervision while handling hot coffee or requiring assistance with eating).

Review of the progress notes dated 10/6/18, at 10:18 a.m. indicated dietary staff had reported R1 as having more difficulty feeding herself. The note indicated options were discussed and a lip plate was implemented.

Review of the nursing progress notes for 11/21/18 did not reveal any mention of a coffee spill or burn injury to R1's shoulder or chest, nor any evidence of a physical assessment being completed by a licensed nurse after R1 spilled coffee on herself. The notes did not contain evidence of any other monitoirng or skin checks being completed over the next 24 hours to monitor the extent of the injury sustained during this event. Review of R1's current care plan did not reveal any changes were made to reflect R1's need for help or increased supervision with hot beverages.

A progress note dated 11/23/18, at 5:56 a.m. indicated R1 was noted to have an open blistered area from the upper chest to between the breast. R1 also was noted to have an intact blister on the abdomen that measured 4 cm (centimeters) wide. The note indicated R1 had reported to staff she spilled hot coffee on herself while she was at home with her family celebrating Thanksgiving on 11/22/18. A subsequent progress note entry at 10:32 a.m. on 11/23/18, indicated R1 had been found during the night with pink itchy skin on her chest. The note indicated R1 had told staff she'd spilled coffee on herself. Blistering was reported by the night staff but had subsided by the time of this note. Staff spoke with F-B who indicated the

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2 835	Continued From page 4	2 835		

burn had happened at the facility prior to her outing on 11/22/18, and he was already aware of the burn the previous day, when he came to the facility to visit and noted R1 holding a washcloth on her shoulder at the time of his visit.

A MD/NP Fax Communication Form, dated 11/23/18 indicated R1 had a burned and blistered area on her chest from spilling hot coffee on herself "2 days ago [11/21/18]" and the blistered area was 8 centimeters by 18 centimeters. The fax was returned signed by the provider on 11/26/18, with orders to clean the affected area twice daily and apply Vaseline.

A progress note entry dated 11/24/18, at 8:47 a.m. indicated R1's chest and abdomen area were pink in color with peeling skin. The note further indicated the resident had been picking a reddenend area on the right side of her chin as well and included, "Will continue to monitor." A progress note at 8:50 a.m. described R1's chest and abdomen to be pink in color and the skin to be peeling, and described a 1 1/2 cm by 2 cm reddened area was noted on the right side of the resident's chin. The note indicated R1 believed this was caused by the hot coffee she'd spilled and included, "Waiting for an order from the physician for treatment to the burned skin areas and will continue to monitor."

A nursing progress note dated 11/26/18, at 4:15 p.m. indicated a physician order had been received to apply Vaseline to R1's burned skin areas until healed.

A progress note dated 11/28/18, at 10:09 a.m. included, "[R1's] chest skin remains intact but is greenish in color underneath the skin. Reported to certified nurse practitioner (CNP)-A and

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2 835	Continued From page 5	2 835		

obtained an order for silvadene cream twice a day (bid)." A progress note dated 11/29/18, at 10:09 a.m. indicated R1's burns measured 7cm wide at the sternal region and 16 cm in length from sternum to the abdominal region. The note described the burn as having "yellowish and green pockets of exudate noted throughout" the lesion/burn.

A progress note dated 11/28/18 at 11:04 a.m., indicated a physician's order had been received for R1 to continue with silvadene cream bid (twice a day) for 2 weeks. At that time, the note also indicated R1 had been examined by CNP-A who had indicated R1's lesion/burn was showing early signs of healing.

A progress note dated 11/30/18, at 2:09 p.m. indicated an appointment had been made for R1 to be seen at urgent care on 12/1/18, to assess her burns.

A progress note dated 12/1/18, at 2:20 p.m. indicated R1 had been taken to urgent care by F-A and the facility staff received a call from CNP-B from urgent care at that time. CNP-B reported to the facility staff he had filed a complaint to the State Agency related to R1's burns. The note indicated CNP-B had told facility staff F-A reported to him R1's burns had happened at the health care facility where she resided. A referral was made by CNP-B for R1 to be seen on 12/3/18, at Regions Burn Center for evaluation and treatment. Prior to the appointment, orders were to continue silvadene cream treatment to the burns.

A progress note dated 12/3/18, indicated R1 returned from an appointment at Regions Burn Clinic with orders to continue with the silvadene

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2 835	Continued From page 6 cream treatment. During observation of the breakfast meal on 12/7/18, at 8:54 a.m. R1 was sitting in the first floor north assisted dining room. Nursing assistant (NA)-A was observed to assist R1 with meal preparation and fed R1 bites of egg from a spoon. R1 was further observed to independently grab a piece of toast from her plate, and eat it. During the meal, NA-A handed R1 a glass of milk which R1 consumed, and R1 set the glass back down on the table independently. During observation of R1's chest burn treatment on 12/7/18, at 10:05 a.m. RN-B obtained dressing change supplies, washed hands, applied gloves, and removed gauze wrapping to R1's chest area. The area was cleansed with saline and gauze, and measurements obtained. RN-B identified the red and superficial open chaffed chest area as a burn measuring 8 cm across by 18 cm down. RN-B identified two spearate areas of yellowish soft scab like areas mid sternum measuring 2 cm by 3 cm, and 1 cm by 1 cm to the lower sternum. Silver sulfadiazine 1% premoistened gauze was applied, nonstick pads were placed over the area, and the area was wrapped with kerlix. RN-B stated identified the area was healing with no signs and symptoms of infection. A physician visit progress note dated 12/1/18, during an urgent care visit. CNP-B indicated R1 was seen at urgent care with a burn to the chest. R1 was examined and observed to have a burn in the area of the sternum from the sternoclavicular notch to just below the xiphoid, with some burns on the abdomen bilaterally. The area was described as having honey crusted skin over the heart area with no swelling around the edges of the burn. The note indicated no infection was	2 835		

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2 835	Continued From page 7 identified but indicated a referral had been made to Regions Burn Center for a consult for treatment. Orders to continue silvadene cream. CNP-B indicated R1's family (F)-B reported R1 often was unable to feed herself, and the nursing home staff gave her hot coffee on 2 occasions (a few days before Thanksgiving and the day of Thanksgiving) which she spilled on her chest. F-B indicated he had contacted the nursing home where R1 resides to inform them he had filed a vulnerable adult (VA) complaint. The progress note further indicated the facility informed him R1 had spilled hot coffee while out on an outing with family over Thanksgiving. Due to the information received from the family, CNP-B indicated he was required to file a vulnerable adult to the State related to potential neglect. During interview on 12/7/18, at 9:18 a.m. nursing assistant (NA)-B stated R1 was shaky at times, had poor vision, and had a tendency to spill food and fluids. NA-B further stated staff had needed to guide and assist R1 with food and fluids for the last couple of months. During a subsequent interview 12/7/18, at 9:50 a.m. NA-B stated staff can ususally guide beverages to R1's lips and let go, but sometimes R1 will grab the beverage before staff are ready to help her. NA-B stated R1's ability and shakiness varied daily. NA-B was not aware of R1 spilling coffee other than when she had went out with family on Thanksgiving, and further stated coffee wasn't allowed for R1 unless she had assistance to drink it. NA-B also stated R1 required no special equipment to drink beverages. During interview on 12/7/18, at 9:57 a.m. registered nurse (RN)-B stated R1 had spilled	2 835		

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	00138	A. BUILDING: _____ B. WING _____	C 12/07/2018

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2 835	Continued From page 8	2 835		

coffee in the afternoon at the facility a week or so ago and had obtained a superficial pink area. RN-B stated since that time R1 had received increased supervision of her meals and coffee. RN-B stated the burn to R1's chest area was identified by night shift staff the morning of 11/23/18, and had been brought to her attention. RN-B stated she had assessed the area to R1's chest at that time but it was not red, weeping or painful. RN-B said the area had appeared as if the resident had been rubbing it. RN-B stated she had notified the physician per fax at that time, but wasn't sure when the burn had occurred.

During a telephone interview with F-A on 12/7/18 at 10:00 a.m., F-A stated he was aware of R1's burns. F-A stated he did not think R1's burns occurred on Thanksgiving while out with family. F-A stated he had thought F-B had told him R1 may have burned herself at the nursing home, but could not verify. F-A further stated F-B may be able to give more information on when R1's burn occured and where.

During interview on12/7/18, at 10:21 a.m. NA-A stated R1 had required more assistance with meals in the last month or so due to her shakiness. NA-A further stated R1 required help to guide or prompt her to eat and get the glass to her mouth. NA-A stated R1 "can have coffee, but needs assistance and staff must stay with her when drinking it."

During observation and interview on 12/7/18, at 12:45 p.m. with the certified dietary manager (CDM), the temperature of the facility coffee was noted to be 188.6 degrees Fahrenheit when dispensed directly from the coffee machine into a carafe the facility would typically use for distribution. The CDM stated the carafes were

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2 835	Continued From page 9 insulated to help keep hot liquids warm for about 4-6 hours, however, the facility often ended up reheating coffee for residents. During a telephone interview on 12/7/18 at 12:52 p.m., CNP-B stated R1 had been seen at Urgent Care on 12/1/18, related to coffee burns on her chest area. CNP-B stated F-A informed him R1 was not getting the assistance she needed and had been spilling hot coffee on herself causing skin burns. CNP-B further stated F-B informed him the nursing home staff had not been doing anything about the burn other than a vaseline application treatment and that R1 had not been examined by a medical provider. CNP -B stated he felt R1's burns to the chest area were significant enough for further treatment and intervention to include a referral to Regions Burn Clinic. During an interview with the director of nursing (DON) on 12/7/18, at 11:01 a.m. the DON stated she'd become aware of R1's burn concerns when she'd recieved a call from CNP-B from Urgent Care on 12/1/18. The DON stated that she had completed an investigation related to the burns. The DON stated through staff interview it was determined R1 had spilled hot coffee on herself at the facility on 11/21/18 and had obtained a small red area on the right shoulder that subsided a couple hours later. The DON further stated that through interview it was determined F-B had reported to two staff the resident had spilled hot coffee on herself while with family on 11/22/18 when they were celebrating Thanksgiving. The DON stated she assumed interventions had been put in place after R1 spilled hot coffee on herself on 11/21/18, but confirmed no changes had been made with the resident's plan of care.	2 835		

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2 835	Continued From page 10 RN-A stated during interview on 12/7/18, at 11:44 a.m. R1 had spilled coffee on herself about 3 months ago (9/18), but had not gotten burned. RN-A stated at that time she'd felt it was an isolated situation because it was a visitor that gave her the coffee and not one of the staff members. RN-A further stated she was aware of R1's reddened right shoulder on 11/21/18, after R1 had spilled hot coffee on herself. RN-A stated the staff had been instructed not to leave R1 alone when given hot coffee, however, this intervention had not been added to the plan of care for all staff to be aware of. RN-A further stated R1 had recently experienced a decline in condition and required increased supervision and assistance with eating. RN-A also said R1's assessment period was next week and the plan of care would be updated at that time. During interview on 12/7/18, at 12:05 p.m. licensed practical nurse (LPN)-A stated F-A told her R1 had spilled coffee when out with family for Thanksgiving. LPN-A further stated she was not aware of any interventions or precautions related to R1 and coffee. LPN-A stated, "If [R1] wants coffee, she can have it." During interview on 12/7/18, at 12:10 p.m. NA-C stated R1 had gone out with family on Thanksgiving day 11/22/18. NA-C stated after R1 had returned she'd assisted R1 with evening cares, and had notified the nurse her chest area and under breasts was rashy in appearance, however, could not recall R1's clothing being stained with coffee upon her return to the facility. During interview on 12/7/18, at 3:40 p.m. NA-D stated she had given R1 a cup of coffee from the snack cart on 11/21/18. NA-D stated she had filled a styrofoam cup about 1/4 full of coffee.	2 835		

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2 835	Continued From page 11 NA-D stated almost immediately R1 had put her call light on because she'd spilled the coffee. NA-D said she'd answered the light, and had noted the coffee had been spilled on R1's shoulder. NA-D stated she'd looked at R1's skin under her shirt, noticed the area was pink, obtained a cold wash cloth, and had notified the nurse. NA-D stated she had never known the resident to spill coffee but was aware that she frequntly spilled other liquids indicating that was why only a 1/4 cup of coffee had been provided to the resident. NA-D stated, "Now staff need to sit and assist [R1] to drink coffee." A telephone call was placed to F-B on 12/7/18, at 9:00 a.m. and 12/17/18, at 2:30 p.m., but there was no return call. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise facility policies involving assistance with eating and drinking fluids, and/or review and revise policies related to incidents and accident hazards, and educate all staff. The director of nursing or designee could audit residents to ensure they are receiving adequate care and supervision with eating activities, and assess whether or not they need adaptive equipment for safety. The director of nursing or designee could report the findings of the audits to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Report #: H5338030M
Compliance #: H5338029

Date Concluded: March 26, 2019
Date of Visit: March 1, 2019

Name, Address, and County of Facility Investigated:
St. John's Lutheran Home
901 Luther Place
Albert Lea, MN 56007
Freeborn County

Facility Type: Nursing Home

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An allegation of maltreatment was investigated in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged that the facility neglected to develop and implement interventions to minimize the risk of injury for a resident who sustained a burn to the sternum.

Investigative Findings and Conclusion:
Neglect was substantiated. The resident required feeding assistance, but the facility did not change the care plan or implement interventions for hot beverages. The facility staff gave the resident hot coffee, which she spilled on herself, and sustained second degree burns across her chest and abdomen.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and dietary staff. The investigator reviewed resident records, facility policies, incident reports, and grievances. The investigator reviewed urgent care records, hospital records, and family provided photos of the resident's burns.

The resident admitted to the facility with diagnoses that included dementia, history of falls, essential tremors, and cataracts. The care plan indicated the resident ate independently after staff set up the food tray and opened condiments and containers. The nursing assistant care plan identified the resident as vision impaired and noted she required staff supervision while eating to watch for signs of choking. There were no restrictions on hot beverages, and the resident enjoyed coffee.

The resident ate in the dining room until progression of disease made it difficult for the resident to eat independently. Several months before the incident, staff moved the resident to the solarium for meals, along with others who required assistance with eating. Staff allowed the resident to drink coffee independently.

One morning at breakfast, the resident spilled a cup of coffee on her chest. When a visiting family member came, he noticed a coffee stain and asked the staff to change the resident's shirt in preparation for an outing. The resident returned from the outing, and staff put pajamas on her and assisted the resident to bed. The next morning a staff member noticed an open blister on the resident's chest and an intact blister on the resident's abdomen. The facility attempted to contact the resident's nurse practitioner but, due to a communication mix-up, did not get treatment orders for the burn until three days later.

The facility made no changes to the resident's care plan with regard to hot beverages and assistance with eating.

The resident received examination and treatment at urgent care and ongoing treatment at a burn center.

During interviews, facility staff members said the resident used to be able to feed herself, but decompensated to need total staff assistance with food and beverages. The staff members indicated "all staff" knew this.

During interviews, family members said they had seen the resident with coffee spills on her clothing on several occasions.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"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.

Vulnerable Adult interviewed: No. Unable to interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility updated the resident's care plan to indicate staff were to cool hot beverages and use a cup lid. Staff were to stay with the resident during meals or when having hot beverages. Staff received education.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.cfm, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: Health Regulation Division – Licensing and Certification
The Office of Ombudsman for Long-Term Care
Albert Lea Police Department
Albert Lea City Attorney
Freeborn County Attorney

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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 on 12/7/18, to investigate complaint #H5338029. As a result the following orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of	2 000		

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2 000	Continued From page 1 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		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to minimize the risk of injury for 1 of 3 residents (R1) who was reviewed for accidents, who had a history of difficulty managing food and liquids during eating activities. R1 sustained actual harm when she received a burn to the sternum requiring a physician visit and referral to a burn clinic. Findings include:	2 835	Corrected	1/11/19

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2 835	Continued From page 2 R1's current diagnosis listing included: anxiety disorder, major depressive disorder, muscle weakness, history of falls with fractures, syncopal episodes (fainting), osteoporosis and chronic kidney disease. Review of the current quarterly minimum data set (MDS) assessment dated 9/25/18, identified R1 as having a brief interview for mental status (BIMS) score of "13" (meaning cognitively intact). R1 understands and is understood. R1 eats independently with set up help. No impairments in upper and lower extremities. A quarterly nutritional assessment dated 9/25/18, identified R1 as being independent with eating. R1 does not utilize adaptive devices during eating and has no skin concerns. A quarterly skin assessment dated 9/24/18, identified R1 with no skin impairments. R1's skin is assessed during daily cares and during weekly bathing. Review of the current plan of care, identifies R1 as having an alteration in thought process related to syncope/collapse and impaired glucose. The care plan further indicated: R1 has good memory recall, understands and is understood. R1 is independent with eating with assistance of tray set up and opening condiments/containers. R1 has impairment with vision and physical mobility, related to weakness and impaired safety awareness. (The care plan did not include supervision while handling hot coffee or requiring assistance with eating). A current nursing assistant (NA) care plan identified R1 as having impaired vision, and indicated the resident usually understands and is understood. Additionally, the NA care plan identified R1 as independent with	2 835		

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2 835	Continued From page 3 eating with assist to set up tray, and requires staff supervision for signs of choking. (The NA care plan did not include supervision while handling hot coffee or requiring assistance with eating). Review of the progress notes dated 10/6/18, at 10:18 a.m. indicated dietary staff had reported R1 as having more difficulty feeding herself. The note indicated options were discussed and a lip plate was implemented. Review of the nursing progress notes for 11/21/18 did not reveal any mention of a coffee spill or burn injury to R1's shoulder or chest, nor any evidence of a physical assessment being completed by a licensed nurse after R1 spilled coffee on herself. The notes did not contain evidence of any other monitoirng or skin checks being completed over the next 24 hours to monitor the extent of the injury sustained during this event. Review of R1's current care plan did not reveal any changes were made to reflect R1's need for help or increased supervision with hot beverages. A progress note dated 11/23/18, at 5:56 a.m. indicated R1 was noted to have an open blistered area from the upper chest to between the breast. R1 also was noted to have an intact blister on the abdomen that measured 4 cm (centimeters) wide. The note indicated R1 had reported to staff she spilled hot coffee on herself while she was at home with her family celebrating Thanksgiving on 11/22/18. A subsequent progress note entry at 10:32 a.m. on 11/23/18, indicated R1 had been found during the night with pink itchy skin on her chest. The note indicated R1 had told staff she'd spilled coffee on herself. Blistering was reported by the night staff but had subsided by the time of this note. Staff spoke with F-B who indicated the	2 835		

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2 835	Continued From page 4 burn had happened at the facility prior to her outing on 11/22/18, and he was already aware of the burn the previous day, when he came to the facility to visit and noted R1 holding a washcloth on her shoulder at the time of his visit. A MD/NP Fax Communication Form, dated 11/23/18 indicated R1 had a burned and blistered area on her chest from spilling hot coffee on herself "2 days ago [11/21/18]" and the blistered area was 8 centimeters by 18 centimeters. The fax was returned signed by the provider on 11/26/18, with orders to clean the affected area twice daily and apply Vaseline. A progress note entry dated 11/24/18, at 8:47 a.m. indicated R1's chest and abdomen area were pink in color with peeling skin. The note further indicated the resident had been picking a reddenend area on the right side of her chin as well and included, "Will continue to monitor." A progress note at 8:50 a.m. described R1's chest and abdomen to be pink in color and the skin to be peeling, and described a 1 1/2 cm by 2 cm reddened area was noted on the right side of the resident's chin. The note indicated R1 believed this was caused by the hot coffee she'd spilled and included, "Waiting for an order from the physician for treatment to the burned skin areas and will continue to monitor." A nursing progress note dated 11/26/18, at 4:15 p.m. indicated a physician order had been received to apply Vaseline to R1's burned skin areas until healed. A progress note dated 11/28/18, at 10:09 a.m. included, "[R1's] chest skin remains intact but is greenish in color underneath the skin. Reported to certified nurse practitioner (CNP)-A and	2 835		

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2 835	Continued From page 5 obtained an order for silvadene cream twice a day (bid)." A progress note dated 11/29/18, at 10:09 a.m. indicated R1's burns measured 7cm wide at the sternal region and 16 cm in length from sternum to the abdominal region. The note described the burn as having "yellowish and green pockets of exudate noted throughout" the lesion/burn. A progress note dated 11/28/18 at 11:04 a.m., indicated a physician's order had been received for R1 to continue with silvadene cream bid (twice a day) for 2 weeks. At that time, the note also indicated R1 had been examined by CNP-A who had indicated R1's lesion/burn was showing early signs of healing. A progress note dated 11/30/18, at 2:09 p.m. indicated an appointment had been made for R1 to be seen at urgent care on 12/1/18, to assess her burns. A progress note dated 12/1/18, at 2:20 p.m. indicated R1 had been taken to urgent care by F-A and the facility staff received a call from CNP-B from urgent care at that time. CNP-B reported to the facility staff he had filed a complaint to the State Agency related to R1's burns. The note indicated CNP-B had told facility staff F-A reported to him R1's burns had happened at the health care facility where she resided. A referral was made by CNP-B for R1 to be seen on 12/3/18, at Regions Burn Center for evaluation and treatment. Prior to the appointment, orders were to continue silvadene cream treatment to the burns. A progress note dated 12/3/18, indicated R1 returned from an appointment at Regions Burn Clinic with orders to continue with the silvadene	2 835		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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2 835	Continued From page 6 cream treatment. During observation of the breakfast meal on 12/7/18, at 8:54 a.m. R1 was sitting in the first floor north assisted dining room. Nursing assistant (NA)-A was observed to assist R1 with meal preparation and fed R1 bites of egg from a spoon. R1 was further observed to independently grab a piece of toast from her plate, and eat it. During the meal, NA-A handed R1 a glass of milk which R1 consumed, and R1 set the glass back down on the table independently. During observation of R1's chest burn treatment on 12/7/18, at 10:05 a.m. RN-B obtained dressing change supplies, washed hands, applied gloves, and removed gauze wrapping to R1's chest area. The area was cleansed with saline and gauze, and measurements obtained. RN-B identified the red and superficial open chaffed chest area as a burn measuring 8 cm across by 18 cm down. RN-B identified two spearate areas of yellowish soft scab like areas mid sternum measuring 2 cm by 3 cm, and 1 cm by 1 cm to the lower sternum. Silver sulfadiazine 1% premoistened gauze was applied, nonstick pads were placed over the area, and the area was wrapped with kerlix. RN-B stated identified the area was healing with no signs and symptoms of infection. A physician visit progress note dated 12/1/18, during an urgent care visit. CNP-B indicated R1 was seen at urgent care with a burn to the chest. R1 was examined and observed to have a burn in the area of the sternum from the sternoclavicular notch to just below the xiphoid, with some burns on the abdomen bilaterally. The area was described as having honey crusted skin over the heart area with no swelling around the edges of the burn. The note indicated no infection was	2 835		

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2 835	Continued From page 7 identified but indicated a referral had been made to Regions Burn Center for a consult for treatment. Orders to continue silvadene cream. CNP-B indicated R1's family (F)-B reported R1 often was unable to feed herself, and the nursing home staff gave her hot coffee on 2 occasions (a few days before Thanksgiving and the day of Thanksgiving) which she spilled on her chest. F-B indicated he had contacted the nursing home where R1 resides to inform them he had filed a vulnerable adult (VA) complaint. The progress note further indicated the facility informed him R1 had spilled hot coffee while out on an outing with family over Thanksgiving. Due to the information received from the family, CNP-B indicated he was required to file a vulnerable adult to the State related to potential neglect. During interview on 12/7/18, at 9:18 a.m. nursing assistant (NA)-B stated R1 was shaky at times, had poor vision, and had a tendency to spill food and fluids. NA-B further stated staff had needed to guide and assist R1 with food and fluids for the last couple of months. During a subsequent interview 12/7/18, at 9:50 a.m. NA-B stated staff can ususally guide beverages to R1's lips and let go, but sometimes R1 will grab the beverage before staff are ready to help her. NA-B stated R1's ability and shakiness varied daily. NA-B was not aware of R1 spilling coffee other than when she had went out with family on Thanksgiving, and further stated coffee wasn't allowed for R1 unless she had assistance to drink it. NA-B also stated R1 required no special equipment to drink beverages. During interview on 12/7/18, at 9:57 a.m. registered nurse (RN)-B stated R1 had spilled	2 835		

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2 835	Continued From page 8 coffee in the afternoon at the facility a week or so ago and had obtained a superficial pink area. RN-B stated since that time R1 had received increased supervision of her meals and coffee. RN-B stated the burn to R1's chest area was identified by night shift staff the morning of 11/23/18, and had been brought to her attention. RN-B stated she had assessed the area to R1's chest at that time but it was not red, weeping or painful. RN-B said the area had appeared as if the resident had been rubbing it. RN-B stated she had notified the physician per fax at that time, but wasn't sure when the burn had occurred. During a telephone interview with F-A on 12/7/18 at 10:00 a.m., F-A stated he was aware of R1's burns. F-A stated he did not think R1's burns occurred on Thanksgiving while out with family. F-A stated he had thought F-B had told him R1 may have burned herself at the nursing home, but could not verify. F-A further stated F-B may be able to give more information on when R1's burn occured and where. During interview on12/7/18, at 10:21 a.m. NA-A stated R1 had required more assistance with meals in the last month or so due to her shakiness. NA-A further stated R1 required help to guide or prompt her to eat and get the glass to her mouth. NA-A stated R1 "can have coffee, but needs assistance and staff must stay with her when drinking it." During observation and interview on 12/7/18, at 12:45 p.m. with the certified dietary manager (CDM), the temperature of the facility coffee was noted to be 188.6 degrees Fahrenheit when dispensed directly from the coffee machine into a carafe the facility would typically use for distribution. The CDM stated the carafes were	2 835		

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2 835	Continued From page 9 insulated to help keep hot liquids warm for about 4-6 hours, however, the facility often ended up reheating coffee for residents. During a telephone interview on 12/7/18 at 12:52 p.m., CNP-B stated R1 had been seen at Urgent Care on 12/1/18, related to coffee burns on her chest area. CNP-B stated F-A informed him R1 was not getting the assistance she needed and had been spilling hot coffee on herself causing skin burns. CNP-B further stated F-B informed him the nursing home staff had not been doing anything about the burn other than a vaseline application treatment and that R1 had not been examined by a medical provider. CNP -B stated he felt R1's burns to the chest area were significant enough for further treatment and intervention to include a referral to Regions Burn Clinic. During an interview with the director of nursing (DON) on 12/7/18, at 11:01 a.m. the DON stated she'd become aware of R1's burn concerns when she'd recieved a call from CNP-B from Urgent Care on 12/1/18. The DON stated that she had completed an investigation related to the burns. The DON stated through staff interview it was determined R1 had spilled hot coffee on herself at the facility on 11/21/18 and had obtained a small red area on the right shoulder that subsided a couple hours later. The DON further stated that through interview it was determined F-B had reported to two staff the resident had spilled hot coffee on herself while with family on 11/22/18 when they were celebrating Thanksgiving. The DON stated she assumed interventions had been put in place after R1 spilled hot coffee on herself on 11/21/18, but confirmed no changes had been made with the resident's plan of care.	2 835		

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2 835	Continued From page 10 RN-A stated during interview on 12/7/18, at 11:44 a.m. R1 had spilled coffee on herself about 3 months ago (9/18), but had not gotten burned. RN-A stated at that time she'd felt it was an isolated situation because it was a visitor that gave her the coffee and not one of the staff members. RN-A further stated she was aware of R1's reddened right shoulder on 11/21/18, after R1 had spilled hot coffee on herself. RN-A stated the staff had been instructed not to leave R1 alone when given hot coffee, however, this intervention had not been added to the plan of care for all staff to be aware of. RN-A further stated R1 had recently experienced a decline in condition and required increased supervision and assistance with eating. RN-A also said R1's assessment period was next week and the plan of care would be updated at that time. During interview on 12/7/18, at 12:05 p.m. licensed practical nurse (LPN)-A stated F-A told her R1 had spilled coffee when out with family for Thanksgiving. LPN-A further stated she was not aware of any interventions or precautions related to R1 and coffee. LPN-A stated, "If [R1] wants coffee, she can have it." During interview on 12/7/18, at 12:10 p.m. NA-C stated R1 had gone out with family on Thanksgiving day 11/22/18. NA-C stated after R1 had returned she'd assisted R1 with evening cares, and had notified the nurse her chest area and under breasts was rashy in appearance, however, could not recall R1's clothing being stained with coffee upon her return to the facility. During interview on 12/7/18, at 3:40 p.m. NA-D stated she had given R1 a cup of coffee from the snack cart on 11/21/18. NA-D stated she had filled a styrofoam cup about 1/4 full of coffee.	2 835		

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2 835	Continued From page 11 NA-D stated almost immediately R1 had put her call light on because she'd spilled the coffee. NA-D said she'd answered the light, and had noted the coffee had been spilled on R1's shoulder. NA-D stated she'd looked at R1's skin under her shirt, noticed the area was pink, obtained a cold wash cloth, and had notified the nurse. NA-D stated she had never known the resident to spill coffee but was aware that she frequntly spilled other liquids indicating that was why only a 1/4 cup of coffee had been provided to the resident. NA-D stated, "Now staff need to sit and assist [R1] to drink coffee." A telephone call was placed to F-B on 12/7/18, at 9:00 a.m. and 12/17/18, at 2:30 p.m., but there was no return call. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise facility policies involving assistance with eating and drinking fluids, and/or review and revise policies related to incidents and accident hazards, and educate all staff. The director of nursing or designee could audit residents to ensure they are receiving adequate care and supervision with eating activities, and assess whether or not they need adaptive equipment for safety. The director of nursing or designee could report the findings of the audits to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		

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F 000	INITIAL COMMENTS An unannounced survey was conducted on 12/7/18 to investigate complaint #H5338029. St Johns Lutheran Community was NOT found in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. #H5338029 was substantiated at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to minimize the risk of injury for 1 of 3 residents (R1) who was reviewed	F 689	F689 □ 1.) Corrective action for the alleged deficient practice: Resident R1□s plan of care was updated to state Cool any hot	1/11/19

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

Electronically Signed | 01/10/2019

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 689	Continued From page 1 for accidents, who had a history of difficulty managing food and liquids during eating activities. R1 sustained actual harm when she received a burn to the sternum requiring a physician visit and referral to a burn clinic. Findings include: R1's current diagnosis listing included: anxiety disorder, major depressive disorder, muscle weakness, history of falls with fractures, syncopal episodes (fainting), osteoporosis and chronic kidney disease. Review of the current quarterly minimum data set (MDS) assessment dated 9/25/18, identified R1 as having a brief interview for mental status (BIMS) score of "13" (meaning cognitively intact). R1 understands and is understood. R1 eats independently with set up help. No impairments in upper and lower extremities. A quarterly nutritional assessment dated 9/25/18, identified R1 as being independent with eating. R1 does not utilize adaptive devices during eating and has no skin concerns. A quarterly skin assessment dated 9/24/18, identified R1 with no skin impairments. R1's skin is assessed during daily cares and during weekly bathing. Review of the current plan of care, identifies R1 as having an alteration in thought process related to syncope/collapse and impaired glucose. The care plan further indicated: R1 has good memory recall, understands and is understood. R1 is independent with eating with assistance of tray set up and opening condiments/containers. R1	F 689	beverages before serving. Use a lid for cup. Use a lip plate for meals. Eat meals in the solarium/assisted table. Never leave resident unattended with meal or hot liquids. Inform family and friends of her need for assistance and not to serve her hot coffee. The care plan was also updated to state that she requires total tray set up, assist of 1 to start/finish, but can feed herself part of her meal with cues/encouragement and adaptive silverware. Education was provided to staff during report at change of shift x 3 days (12/7/18-12/10/18), and the nursing newsletter with paycheck distribution on 12/14/18 and 1/11/18, reminding staff that Residents that require assistance with meals, this includes observation and cueing needs, should never be left alone with their meal, as they are at risk without assistance, and Do not leave residents, who require assistance with eating and drinking, unsupervised with any hot liquids. 2.) Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents who require assistance with eating, including cueing and observation, have the potential to be affected. 1.) Education was provided to staff during report at change of shift x 3 days (12/7/18 -12/10/18), and the nursing newsletter with paycheck distribution on 12/14/18 and 1/11/18, reminding staff that Residents that require assistance with meals, this includes observation and cueing needs, should never be left alone with their meal, as they are at risk without	

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F 689	Continued From page 2 has impairment with vision and physical mobility, related to weakness and impaired safety awareness. (The care plan did not include supervision while handling hot coffee or requiring assistance with eating). A current nursing assistant (NA) care plan identified R1 as having impaired vision, and indicated the resident usually understands and is understood. Additionally, the NA care plan identified R1 as independent with eating with assist to set up tray, and requires staff supervision for signs of choking. (The NA care plan did not include supervision while handling hot coffee or requiring assistance with eating). Review of the progress notes dated 10/6/18, at 10:18 a.m. indicated dietary staff had reported R1 as having more difficulty feeding herself. The note indicated options were discussed and a lip plate was implemented. Review of the nursing progress notes for 11/21/18 did not reveal any mention of a coffee spill or burn injury to R1's shoulder or chest, nor any evidence of a physical assessment being completed by a licensed nurse after R1 spilled coffee on herself. The notes did not contain evidence of any other monitoirng or skin checks being completed over the next 24 hours to monitor the extent of the injury sustained during this event. Review of R1's current care plan did not reveal any changes were made to reflect R1's need for help or increased supervision with hot beverages. A progress note dated 11/23/18, at 5:56 a.m. indicated R1 was noted to have an open blistered area from the upper chest to between the breast. R1 also was noted to have an intact blister on the abdomen that measured 4 cm (centimeters)	F 689	assistance, and Do not leave residents, who require assistance with eating and drinking, unsupervised with any hot liquids. 2.) A policy and procedure was implemented in regards to burns, and includes updating the plan of care to reflect changes implemented to prevent further burns. Copies of this were available for nurses to pick up with their paychecks on 1/11/18. 3.) Nurse Managers were given an auditing form to complete that looked at which residents required assistance with their meals, including cueing and observation, and if their plan of care reflected this. If not, the plan of care was to be updated. The Nurse Managers will complete this by January 11, 2019. 3.) Measures/Systematic changes put in place to assure the alleged deficient practice does not re-occur: Nurse Managers will complete monthly audits on residents who require assistance with eating, and verify that their plan of care reflects this. A burn policy/procedure was implemented. Education was provided to staff reminding them that residents who require assistance with meals, including observation and cueing, should never be left alone with their meal, as they are at risk without assistance; and not to leave residents, who require assistance with eating and drinking, unsupervised with any hot liquids. 4.) Corrective actions will be monitored to ensure the alleged deficient practice will not re-occur: Continued audits by Nurse Managers of residents who require assistance with eating, and the adequacy	

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F 689	Continued From page 3 wide. The note indicated R1 had reported to staff she spilled hot coffee on herself while she was at home with her family celebrating Thanksgiving on 11/22/18. A subsequent progress note entry at 10:32 a.m. on 11/23/18, indicated R1 had been found during the night with pink itchy skin on her chest. The note indicated R1 had told staff she'd spilled coffee on herself. Blistering was reported by the night staff but had subsided by the time of this note. Staff spoke with F-B who indicated the burn had happened at the facility prior to her outing on 11/22/18, and he was already aware of the burn the previous day, when he came to the facility to visit and noted R1 holding a washcloth on her shoulder at the time of his visit. A MD/NP Fax Communication Form, dated 11/23/18 indicated R1 had a burned and blistered area on her chest from spilling hot coffee on herself "2 days ago [11/21/18]" and the blistered area was 8 centimeters by 18 centimeters. The fax was returned signed by the provider on 11/26/18, with orders to clean the affected area twice daily and apply Vaseline. A progress note entry dated 11/24/18, at 8:47 a.m. indicated R1's chest and abdomen area were pink in color with peeling skin. The note further indicated the resident had been picking a reddenend area on the right side of her chin as well and included, "Will continue to monitor." A progress note at 8:50 a.m. described R1's chest and abdomen to be pink in color and the skin to be peeling, and described a 1 1/2 cm by 2 cm reddened area was noted on the right side of the resident's chin. The note indicated R1 believed this was caused by the hot coffee she'd spilled and included, "Waiting for an order from the physician for treatment to the burned skin areas	F 689	of their plans of care. Any inconsistencies will be corrected immediately and education provided. The DON or designee will report the findings of the audits to the QA committee for recommendations to ensure ongoing compliance.	

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F 689	Continued From page 4 and will continue to monitor." A nursing progress note dated 11/26/18, at 4:15 p.m. indicated a physician order had been received to apply Vaseline to R1's burned skin areas until healed. A progress note dated 11/28/18, at 10:09 a.m. included, "[R1's] chest skin remains intact but is greenish in color underneath the skin. Reported to certified nurse practitioner (CNP)-A and obtained an order for silvadene cream twice a day (bid)." A progress note dated 11/29/18, at 10:09 a.m. indicated R1's burns measured 7cm wide at the sternal region and 16 cm in length from sternum to the abdominal region. The note described the burn as having "yellowish and green pockets of exudate noted throughout" the lesion/burn. A progress note dated 11/28/18 at 11:04 a.m., indicated a physician's order had been received for R1 to continue with silvadene cream bid (twice a day) for 2 weeks. At that time, the note also indicated R1 had been examined by CNP-A who had indicated R1's lesion/burn was showing early signs of healing. A progress note dated 11/30/18, at 2:09 p.m. indicated an appointment had been made for R1 to be seen at urgent care on 12/1/18, to assess her burns. A progress note dated 12/1/18, at 2:20 p.m. indicated R1 had been taken to urgent care by F-A and the facility staff received a call from CNP-B from urgent care at that time. CNP-B reported to the facility staff he had filed a complaint to the State Agency related to R1's	F 689		

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F 689	Continued From page 5 burns. The note indicated CNP-B had told facility staff F-A reported to him R1's burns had happened at the health care facility where she resided. A referral was made by CNP-B for R1 to be seen on 12/3/18, at Regions Burn Center for evaluation and treatment. Prior to the appointment, orders were to continue silvadene cream treatment to the burns. A progress note dated 12/3/18, indicated R1 returned from an appointment at Regions Burn Clinic with orders to continue with the silvadene cream treatment. During observation of the breakfast meal on 12/7/18, at 8:54 a.m. R1 was sitting in the first floor north assisted dining room. Nursing assistant (NA)-A was observed to assist R1 with meal preparation and fed R1 bites of egg from a spoon. R1 was further observed to independently grab a piece of toast from her plate, and eat it. During the meal, NA-A handed R1 a glass of milk which R1 consumed, and R1 set the glass back down on the table independently. During observation of R1's chest burn treatment on 12/7/18, at 10:05 a.m. RN-B obtained dressing change supplies, washed hands, applied gloves, and removed gauze wrapping to R1's chest area. The area was cleansed with saline and gauze, and measurements obtained. RN-B identified the red and superficial open chaffed chest area as a burn measuring 8 cm across by 18 cm down. RN-B identified two spearate areas of yellowish soft scab like areas mid sternum measuring 2 cm by 3 cm, and 1 cm by 1 cm to the lower sternum. Silver sulfadiazine 1% premoistened gauze was applied, nonstick pads were placed over the area, and the area was wrapped with kerlix. RN-B	F 689		

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	245338	A. BUILDING _____ B. WING _____	C 12/07/2018

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F 689	Continued From page 6 stated identified the area was healing with no signs and symptoms of infection. A physician visit progress note dated 12/1/18, during an urgent care visit. CNP-B indicated R1 was seen at urgent care with a burn to the chest. R1 was examined and observed to have a burn in the area of the sternum from the sternoclavicular notch to just below the xiphoid, with some burns on the abdomen bilaterally. The area was described as having honey crusted skin over the heart area with no swelling around the edges of the burn. The note indicated no infection was identified but indicated a referral had been made to Regions Burn Center for a consult for treatment. Orders to continue silvadene cream. CNP-B indicated R1's family (F)-B reported R1 often was unable to feed herself, and the nursing home staff gave her hot coffee on 2 occasions (a few days before Thanksgiving and the day of Thanksgiving) which she spilled on her chest. F-B indicated he had contacted the nursing home where R1 resides to inform them he had filed a vulnerable adult (VA) complaint. The progress note further indicated the facility informed him R1 had spilled hot coffee while out on an outing with family over Thanksgiving. Due to the information received from the family, CNP-B indicated he was required to file a vulnerable adult to the State related to potential neglect. During interview on 12/7/18, at 9:18 a.m. nursing assistant (NA)-B stated R1 was shaky at times, had poor vision, and had a tendency to spill food and fluids. NA-B further stated staff had needed to guide and assist R1 with food and fluids for the last couple of months. During a subsequent interview 12/7/18, at 9:50	F 689		

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F 689	Continued From page 7 a.m. NA-B stated staff can ususally guide beverages to R1's lips and let go, but sometimes R1 will grab the beverage before staff are ready to help her. NA-B stated R1's ability and shakiness varied daily. NA-B was not aware of R1 spilling coffee other than when she had went out with family on Thanksgiving, and further stated coffee wasn't allowed for R1 unless she had assistance to drink it. NA-B also stated R1 required no special equipment to drink beverages. During interview on 12/7/18, at 9:57 a.m. registered nurse (RN)-B stated R1 had spilled coffee in the afternoon at the facility a week or so ago and had obtained a superficial pink area. RN-B stated since that time R1 had received increased supervision of her meals and coffee. RN-B stated the burn to R1's chest area was identified by night shift staff the morning of 11/23/18, and had been brought to her attention. RN-B stated she had assessed the area to R1's chest at that time but it was not red, weeping or painful. RN-B said the area had appeared as if the resident had been rubbing it. RN-B stated she had notified the physician per fax at that time, but wasn't sure when the burn had occurred. During a telephone interview with F-A on 12/7/18 at 10:00 a.m., F-A stated he was aware of R1's burns. F-A stated he did not think R1's burns occurred on Thanksgiving while out with family. F-A stated he had thought F-B had told him R1 may have burned herself at the nursing home, but could not verify. F-A further stated F-B may be able to give more information on when R1's burn occured and where. During interview on12/7/18, at 10:21 a.m. NA-A	F 689		

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F 689	Continued From page 8 stated R1 had required more assistance with meals in the last month or so due to her shakiness. NA-A further stated R1 required help to guide or prompt her to eat and get the glass to her mouth. NA-A stated R1 "can have coffee, but needs assistance and staff must stay with her when drinking it." During observation and interview on 12/7/18, at 12:45 p.m. with the certified dietary manager (CDM), the temperature of the facility coffee was noted to be 188.6 degrees Fahrenheit when dispensed directly from the coffee machine into a carafe the facility would typically use for distribution. The CDM stated the carafes were insulated to help keep hot liquids warm for about 4-6 hours, however, the facility often ended up reheating coffee for residents. During a telephone interview on 12/7/18 at 12:52 p.m., CNP-B stated R1 had been seen at Urgent Care on 12/1/18, related to coffee burns on her chest area. CNP-B stated F-A informed him R1 was not getting the assistance she needed and had been spilling hot coffee on herself causing skin burns. CNP-B further stated F-B informed him the nursing home staff had not been doing anything about the burn other than a vaseline application treatment and that R1 had not been examined by a medical provider. CNP -B stated he felt R1's burns to the chest area were significant enough for further treatment and intervention to include a referral to Regions Burn Clinic. During an interview with the director of nursing (DON) on 12/7/18, at 11:01 a.m. the DON stated she'd become aware of R1's burn concerns when she'd recieved a call from CNP-B from Urgent	F 689		

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F 689	Continued From page 9 Care on 12/1/18. The DON stated that she had completed an investigation related to the burns. The DON stated through staff interview it was determined R1 had spilled hot coffee on herself at the facility on 11/21/18 and had obtained a small red area on the right shoulder that subsided a couple hours later. The DON further stated that through interview it was determined F-B had reported to two staff the resident had spilled hot coffee on herself while with family on 11/22/18 when they were celebrating Thanksgiving. The DON stated she assumed interventions had been put in place after R1 spilled hot coffee on herself on 11/21/18, but confirmed no changes had been made with the resident's plan of care. RN-A stated during interview on 12/7/18, at 11:44 a.m. R1 had spilled coffee on herself about 3 months ago (9/18), but had not gotten burned. RN-A stated at that time she'd felt it was an isolated situation because it was a visitor that gave her the coffee and not one of the staff members. RN-A further stated she was aware of R1's reddened right shoulder on 11/21/18, after R1 had spilled hot coffee on herself. RN-A stated the staff had been instructed not to leave R1 alone when given hot coffee, however, this intervention had not been added to the plan of care for all staff to be aware of. RN-A further stated R1 had recently experienced a decline in condition and required increased supervision and assistance with eating. RN-A also said R1's assessment period was next week and the plan of care would be updated at that time. During interview on 12/7/18, at 12:05 p.m. licensed practical nurse (LPN)-A stated F-A told her R1 had spilled coffee when out with family for Thanksgiving. LPN-A further stated she was not	F 689		

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F 689	Continued From page 10 aware of any interventions or precautions related to R1 and coffee. LPN-A stated, "If [R1] wants coffee, she can have it." During interview on 12/7/18, at 12:10 p.m. NA-C stated R1 had gone out with family on Thanksgiving day 11/22/18. NA-C stated after R1 had returned she'd assisted R1 with evening cares, and had notified the nurse her chest area and under breasts was rashy in appearance, however, could not recall R1's clothing being stained with coffee upon her return to the facility. During interview on 12/7/18, at 3:40 p.m. NA-D stated she had given R1 a cup of coffee from the snack cart on 11/21/18. NA-D stated she had filled a styrofoam cup about 1/4 full of coffee. NA-D stated almost immediately R1 had put her call light on because she'd spilled the coffee. NA-D said she'd answered the light, and had noted the coffee had been spilled on R1's shoulder. NA-D stated she'd looked at R1's skin under her shirt, noticed the area was pink, obtained a cold wash cloth, and had notified the nurse. NA-D stated she had never known the resident to spill coffee but was aware that she frequntly spilled other liquids indicating that was why only a 1/4 cup of coffee had been provided to the resident. NA-D stated, "Now staff need to sit and assist [R1] to drink coffee." A telephone call was placed to F-B on 12/7/18, at 9:00 a.m. and 12/17/18, at 2:30 p.m., but there was no return call.	F 689		