

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Wildflower Lodge Facility Address: 9251 Black Oaks Lane North			Report Number: HL21386004 and — HL21386005	Date of Visit: May 4, 2017 Date Concluded: July 7, 2017	
			Time of Visit: 8:15 a.m. to 5:40 p.m.		
Facility City: Maple Grove			Investigator's Name and Title: Casey DeVries, RN, Special Investigator		
State: Minnesota	ZIP: 55311	County: Hennepin			

Allegation(s):

It is alleged that a client was neglected when facility staff failed to ensure a door was closed and locked properly, resulting in the client falling in his/her wheelchair down a flight of stairs. The client died five days later due to a consequence of blunt force injuries.

- State Statutes for Home Care Providers (MN Statutes, section 144A.43 144A.483)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the home care provider failed to provide the client with a secured unit, a service assessed as necessary to maintain the client's safety. The failure to provide the secured unit contributed to a fall, and the client died five days after the fall due to blunt force injuries from the fall.

The client received services from a provider licensed as a comprehensive home care provider. The client's diagnoses included dementia, cerebral vascular disease, and psychosis. The client required assistance with bathing, dressing, grooming, toileting, transfers, mobility, and medication management. The client's service plan and vulnerability assessment indicated the client was at risk for falls and elopement, and required a secured memory care unit.

The client was escorted in his/her wheelchair to the dining room at 4:10 p.m. on a Thursday. Approximately twenty minutes later, staff were unable to locate the client, prompting a search within the building. Staff found the client laying on the floor at the bottom of a stairwell adjacent to the dining room, with the wheelchair tipped over on its side. The client was bleeding from his/her mouth and nose. The client's

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physician happened to be in the building, and was paged to assess the client. Family members consulted with the physician and elected to have the client treated by the client's existing hospice provider for pain management, without leaving the facility. The client did not return to his/her baseline, and died the following Tuesday as a consequence of blunt force injuries from the fall.

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The facility incident report and internal investigation of the fall indicated the door by which the client exited the unit had not been locking as intended. The door would be closed, but could often be opened by pushing on it.

A police report regarding the incident indicated the client was able to leave the secured unit and gain access to the stairwell through a door designed to be secured by a coded lock system. The door was intended to be able to be opened only after entering a multi-digit code into the security system. The report also indicated the client had made multiple previous attempts to open and exit through the door prior to the incident occurring. It was known by employees, for an extended period of time, that the door was not properly latching and therefore, was not secure.

Review of the maintenance records indicated there were written service record requests by staff on three occasions over a one year time frame, which indicated staff were aware the door did not lock correctly. Interviews with five staff members revealed the issues with the door were also addressed verbally to management and to the maintenance team on several other occasions, either face-to-face or via calling the facility reception desk.

Interviews with three direct care staff revealed they were all aware, for greater than one year, of the door not closing properly. Two of the staff stated the problem was reported to management on multiple occasions. One of the staff also indicated there have been two other instances in the past three years where other clients were able to exit through the same door, although those clients were not injured during those prior incidents.

During an interview with a nurse, s/he indicated awareness of the door not locking properly, for over a year, and stated s/he reported the issue to the former maintenance director and the current executive director multiple times. S/he indicated there was another occurrence with a different client, who was also able to exit the unit through the door approximately three to six months prior to the incident, although that occurrence did not result in an injury. After this incident, this door was not fixed and no other interventions were put in place. The nurse noted that when a similar incident happened on another unit, a deadbolt was added to that door.

An interview with another nurse revealed s/he knew of the issues with the door for three or four years, as s/he recalled the former director of nursing notifying staff, in the past, to closely monitor the door due to the problem.

During an interview, a maintenance staff member stated there was a problem with the door's magnetic plate, causing the door to catch only about every other time it was closed. The maintenance staff member was aware of the on-going issue for at least one year, stating former maintenance personnel could not solve

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the problem either. The maintenance staff member indicated weather changes caused the building to shift, and this caused the issue. S/he stated an outside vendor has been contacted in the past for trouble shooting with the security system itself, but not the building shifting/door sticking problems.

During an interview, a management staff member verified having been told about the door having sticking issues three times in the preceding year. The management staff member referred to the problem with the door as "seasonal changes" that causes the door to shrink and swell. S/he stated similar problems have occurred elsewhere in the building, and noted deadbolts had been placed on the doors of other units to address this issue, after several elopement attempts.

The autopsy report of the client indicated the immediate cause of death was pneumonia, due to or as a consequence of immobilization, due to or as a consequence of blunt force injuries from the fall.

The facility placed on sign on the door to indicate that the door did not always latch, and remind staff to ensure it was closed and locked. Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557) Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557): ☐ Abuse ☐ Financial Exploitation Substantiated
 ■ ☐ Not Substantiated ☐ Inconclusive based on the following information: **Mitigating Factors:** The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the \[\] Individual(s) and/or \[\] Facility is responsible for the ☐ Abuse ☑ Neglect ☐ Financial Exploitation. This determination was based on the following: The facility is responsible for the neglect. The client was assessed as requiring a secure unit and the client's service plan indicated a secure unit would be provided. Staff, including direct care staff, maintenance staff, nurses, and management, were all aware that the unit was frequently not secure due to the door not operating as intended, but no new interventions were put in place to ensure a secure unit was provided. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services

Compliance	
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Minnesota 245C.

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

for possible disqualification in accordance with the provisions of the background study requirements under

State	licensing	orders	were	issued
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tate licensing orders will be available on the MDH website.)
tate Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met he requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not net.
rate licensing orders were issued: 🗵 Yes 🗌 No
tate licensing orders will be available on the MDH website.)
tate Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met he requirements under State Statues for Chapters 144 &144A were not met.
rate licensing orders were issued: 🗵 Yes 🗌 No
tate licensing orders will be available on the MDH website.)
Compliance Notes:
efinitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The	e Investigation included the following:
	cument Review: The following records were reviewed during the investigation:
X	Medical Records
X	Care Guide
X	Medication Administration Records
X	Nurses Notes
X	Assessments
X	Physician Orders
X	Treatment Sheets
X	Care Plan Records
X	Facility Incident Reports
X	ADL (Activities of Daily Living) Flow Sheets
X	Service Plan
Oth	ner pertinent medical records:
X	Medical Examiner Records
X	Police Report
6.0	
-0/2000-5700	ditional facility records:
X	Staff Time Sheets, Schedules, etc.
X	Facility Internal Investigation Reports
X	Facility In-service Records
X	Facility Policies and Procedures Other procify Maintenance less Consulaint less Cofety and its
X	Other, specify: Maintenance log, Complaint log, Safety committee
Nur	mber of additional resident(s) reviewed: Ten
Wei	re residents selected based on the allegation(s)? Yes No N/A
•	ecify:
Wei	re resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes No \bigcirc N/A Specify: Resident deceased Interviews: The following interviews were conducted during the investigation: Interview with reporter(s) Yes \bigcirc N/A \bigcirc No Specify: If unable to contact reporter, attempts were made on: Date: Time: Date: Time: Date: Time: ○ N/A Specify: _____ Interview with family:

Yes ○ No Did you interview the resident(s) identified in allegation: No ○ N/A Specify: Yes Did you interview additional residents? () Yes No Total number of resident interviews: Interview with staff:

Yes O No ○ N/A Specify: **Tennessen Warnings** Tennessen Warning given as required:

Yes O No Total number of staff interviews: Eight Physician Interviewed:

Yes \bigcirc No Nurse Practitioner Interviewed: Yes No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s): () Yes O No N/A Specify: Attempts to contact: Date: Time: Date: Time: Date: Time: If unable to contact was subpoena issued: O Yes, date subpoena was issued O No Were contacts made with any of the following: ☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: Cleanliness Safety Issues

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▼ Facility Tour

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Maple Grove City Attorney

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: С B. WING 05/26/2017 H21386 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0.000 0 000 Initial Comments Minnesota Department of Health is *****ATTENTION****** documenting the State Licensing Correction Orders using federal software. HOME CARE PROVIDER LICENSING Tag numbers have been assigned to **CORRECTION ORDER** Minnesota State Statutes for Home Care Providers. The assigned tag number In accordance with Minnesota Statutes, section appears in the far left column entitled "ID 144A.43 to 144A.482, this correction order(s) has Prefix Tag." The state Statute number and been issued pursuant to a survey. the corresponding text of the state Statute out of compliance is listed in the Determination of whether a violation has been "Summary Statement of Deficiencies" corrected requires compliance with all requirements provided at the Statute number column. This column also includes the findings that are in violation of the state indicated below. When Minnesota Statute requirement after the statement, "This contains several items, failure to comply with any Minnesota requirement is not met as of the items will be considered lack of evidenced by." Following the surveyors' compliance. findings is the Time Period for Correction. **INITIAL COMMENTS:** PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH On May 4, 2017, a complaint investigation was STATES, "PROVIDER'S PLAN OF initiated to investigate complaints #HL21386004 CORRECTION." THIS APPLIES TO and HL21386005. At the time of the survey, FEDERAL DEFICIENCIES ONLY. THIS there were forty clients that were receiving WILL APPEAR ON EACH PAGE. services under the comprehensive license. The following correction orders are issued. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR **VIOLATIONS OF MINNESOTA STATE** STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. 144A.474 subd. 11 (b) (1) and (2). 0 325 144A.44, Subd. 1(14) Free From Maltreatment 0 325 SS=J Subdivision 1. Statement of rights. A person who receives home care services has these rights:

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 0 325 Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act: This MN Requirement is not met as evidenced Based on interview and document review, the licensee failed to ensure a client was free from maltreatment (neglect) for one of one clients (C1) reviewed, when the licensee failed to provide a client with a secured unit, a service assessed as necessary to maintain the client's safety considering the physical and mental capacity of the client. The failure to provide the secured unit contributed to a fall, and the client died five days after the fall due to blunt force injuries from the fall. This practice resulted in a level four violation (a violation that results in serious injury, impairment or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Medical record review revealed C1 was admitted with diagnoses that included dementia, cerebral vascular disease, and psychosis. C1's service plan, dated November 28, 2016, indicated C1 required a secured unit. C1's vulnerability assessment dated, November 28, 2016, indicated C1 was vulnerable to falls and required a safe environment and 24-hour memory care. Review of a document titled "Resident Incident Report," dated January 19, 2017 revealed C1 was

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found by staff at the first landing of a back

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ C 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 0 325 | Continued From page 2 stairwell at 4:30 p.m., to be laying on his/her left side with his/her wheelchair tipped over on its side. The report indicated maintenance had been notified about the door not locking unless it was re-opened and shut, and that notes were on the door at the time of the incident to inform staff to watch door, ensuring it locked. Review of an untitled document dated January 23, 2017, signed by RN-C, indicated the door on the Wolf unit was not locking after each exit and entry, and staff reported there were times the door would stick. The document further indicated maintenance personal found the door to be locking every other time and noted the magnet was not making direct contact with its intended placement, but rather, was hitting the doorframe. Review of an undated document titled "Internal Investigation for incident for C1", written by ULP-G, indicated the door on Wolf unit was always closed, but was not secure. Review of licensee's service request record, dated January 4, 2016 indicated a request for maintenance was placed by housekeeping for a Wolf unit fire door, regarding a stripped magnet. Review of licensee's service request record, dated September 13, 2016 indicated a request for maintenance was placed by housekeeping for a Wolf unit door regarding a key pad sticking off and on. Review of licensee's service request record,

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not latching properly.

dated January 19, 2017 indicated a request for maintenance was placed by a resident care assistant for a Wolf unit door, regarding the door

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 0 325 Continued From page 3 Review of a police report, dated January 24, 2017, revealed C1 was able to gain access on January 19, 2017, to a stairwell, via a door designed to be secured by a coded lock system. The door was intended to only be able to be opened after entering a multi-digit code into the security system. The police report indicated it was known by employees, for an extended period of time, that the door was not properly latching and therefore was not secure. The police report also indicated C1 had made multiple previous attempts to open and exit through the door, prior to this incident occurring. Review of an autopsy report dated March 24, 2017, revealed C1's immediate cause of death was pneumonia due to or as a consequence of immobilization, due to or as a consequence of blunt force injuries from the fall on January 19, 2017. During an interviw with C1's Primary Care Physician (PCP-K) on June 2, 2017 at 1:40 p.m., PCP-K stated C1 required a secured unit due to very advanced dementia. An interview with unlicensed personnel (ULP-H) on May 10, 2017 at 3:21 p.m. revealed s/he has been aware of the security malfunction of the Wolf unit door for over three years. ULP-H stated the malfunction of the door was very stressful, as s/he felt it necessary to check the security of the door many times when working to ensure it remained locked. ULP-H stated s/he made multiple verbal requests to have the door

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repaired, but was told by the former maintenance director there was nothing more that could be done with the door, ULP-H stated s/he

demonstrated the malfunction on one occasion to the new maintenance director (MD-D), when

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(LPN-E) on May 4, 2017 at 4:10 p.m. revealed s/he was aware of the Wolf door not locking properly for over a year, and stated s/he had

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 0 325 Continued From page 5 0 325 conversations with the former maintenance director about it. LPN-E indicated the former maintenance director said there was nothing that could be done about the door. LPN-E stated there was an occurrence with a different client, who had been able to get through the door approximately three to six months prior to C1's fall. LPN-E stated nothing was done, to his/her knowledge, to rectify the situation with the door following this previous occurrence. LPN-E stated s/he gave multiple verbal reports to the executive director (ED-A) after receiving concerns about the door from other staff, and ED-A's response was s/he would look into it. LPN-E added the Wolf door is not the only door in the facility with a history of security problems, stating the lower level door in the Moose unit has a magnet that no longer holds. LPN-E stated management installed a dead bolt lock to that door after a resident made his/her way through it and was found between the Moose door and an outside door. An interview with Registered Nurse (RN-C) on May 4, 2017 at 2:48 p.m. revealed s/he was aware of issues with the Wolf door sticking around the years 2013 or 2014, because the former director of nursing made it known to everyone to closely monitor the door. RN-C denied awareness of on-going concerns with that door. An interview with Maintenance Director (MD-D) on May 4, 2017 at 1:18 p.m. revealed s/he was not immediately made aware of the incident involving C1, but rather, was informed by the facility receptionist at approximately 10:00 a.m. the following day. Upon inspection, MD-D stated the door was catching about every other time due to an issue with the magnet plate. MD-D stated

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s/he lowered the magnet plate to fix the problem.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
,	.,		A. BUILDING:			
		H21386	B. WING		05/2	6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	3 2 10 2 2	
WILL DEL	OWED LODGE	9251 BLA	CK OAKS LA	ANE NORTH		
WILDFLOWER LODGE MAPLE			ROVE, MN	55311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 325	least a year or more the maintenance di not figure it out, as the building to shift submitting mainten for staff to go throu them up and have to Now, MD-D said, a An interview with E May 4, 2017 at 4:45 Wolf door had issused and swell. ED-A stated and serious issued asked how the door stuck, ED-A stated and that s/he has be so. ED-A stated the closed all of the was stated s/he was told three times in the late any other door to be maintenance right stated two other set facility had dead-be queried why deadb security system we explained that the extra step to make indicated there was making frequent el able to exit the door the facility was unaclient was able to contact the state of the set of the set of the facility was unaclient was able to contact the set of	ge 6 Inew of on-going issues for at e with the door. MD-D stated rector before him/her could weather changes often cause. MD-D stated the process for ance tickets at the time was gh the receptionist to write the tickets delivered to a slot. In electronic system is used. Executive Director (ED-A) on 5 p.m. revealed s/he knew the es, referring to them as which made the door shrink ated s/he was not made aware with the door locking. When recould secure properly if it is you would have to push it een able to secure it by doing at if staff did not get the door sy, it would not lock. ED-A d about the sticking issues ast year, and said if s/he found e sticking s/he would call away to have it looked at. ED-A deadbolt adds an "intentional sure that it's locked." ED-A deadbolt adds an "intentional sure t		DEFICIENCY)		
	doors could be pus	there because otherwise the shed open, ED-A stated she did never personally been able to				

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PRINTED: 06/30/2017 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING H21386 05/26/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 0 325 Continued From page 7 push a door open that was supposed to be locked. ED-A then stated s/he was informed by LPN-E about being able to push through a door thought to be secure prior to the deadbolt installation. ED-A stated she believed the facility needed to implement a more frequent assessment of the doors to determine if they were secured properly. Interview with a family member (FM-J) on May 5, 2017 at 12:51 p.m. revealed s/he was called by staff to come to the facility immediately following C1's fall. FM-J stated s/he was unaware of the door C1 went through as C1 had just moved to the Wolf unit a few weeks prior. FM-J stated his/her spouse took photographs of the Wolf door, indicating signage was in place on the day of the fall warning staff to ensure the door was secure. Review of photographs provided by Family Member (FM-J) via e-mail correspondence on May 9, 2017 revealed two signs were posted to the Wolf door on the day of the fall and read, "Stop, wait for the click, 20 second delay for the lock to engage" and "Please double check that door is locked before you walk away. Door does not like to latch. Shut the door twice. Thank you, Management." Observations made during the on-site visit on

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seconds of holding the door open.

May 4, 2017 from 8:15 a.m. to 5:40 p.m. revealed a paper sign hanging on the Wolf door that read, "Please double check that door is locked before you walk away. Door does not like to latch. Shut door twice. Thank you, Management." The door was unable to be accessed without entering a code. An alarm sounded after approximately thirty

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		H21386	B. WING		05/26	6/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/-	-,
WILDFLO	OWER LODGE		CK OAKS LA	ANE NORTH 55311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 325	A policy regarding of requested; the licer document titled, "V Educational Article. employees are contained and that mandated if they have reason or financial exploits occurred. The document occurred and/or supervalue and/or supervalue for the exploit occurrent occurred. The document occurred for the focare, and/or supervalue for the exploit occurrents titled, Life requested. The licer policy.	vulnerable adults was usee provided an undated ulnerable Adult, An "The document indicates all sidered mandated reporters reporters must make a report to believe that abuse, neglect ation of a vulnerable adult has ument defines neglect as the bod, clothing, shelter, medical	0 325			
0 805 SS=H	This MN Requirem by: Based on interview facility failed to reproduced to the state agency reviewed until five died. This practice result violation that harme	ent is not met as evidenced and document review, the ort a significant fall with injury for one of one client (C1) days later, and after the client ted in a level three violation (a ed a client's health or safety,	0 805	Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far left column entity Prefix Tag." The state Statute numbers assessment of the state of the	oftware. I to le Care liber tled "ID	
	or a violation that h	us injury, impairment, or death, as the potential to lead to airment, or death) and is issued		the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience"		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:		c	
		H21386	B. WING		-	6/2017
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			ROVE, MN 5		211	0.40
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 9	0 805			
	at a pattern scope on number of clients a number of staff are occurred repeatedly pervasive). The find Medical record reviwith diagnoses that vascular disease, a plan, dated Novem required a secured assessment, dated C1 was vulnerable environment and 2. Review of a docum Report," dated Janfound by staff at 4.3 back stairwell, laying wheelchair tipped of Review of a police revealed C1 was a 19, 2017, to a stair secured by a code intended to only be entering a multi-dig system. The police by employees, for a door was not propen not secure. The polad made multiple	(when more than a limited re affected more than a limited involved, or the situation has y but is not found to be dings include: ew revealed C1 was admitted included dementia, cerebral and psychosis. C1's service ber 28, 2016, indicated C1 unit. C1's vulnerability November 28, 2016 indicated to falls, requiring a safe 4-hour memory care. The ent titled, "Resident Incident uary 19, 2017 revealed C1 was 30 p.m., at the first landing of a nig on his/her left side with the		column. This column also included findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Column which States, "Provider 'S Plan Correction." This applies federal deficiencies only Will appear on Each Page. There is no requirement to submit a plan of corrections of minnesotas' Statutes. The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 1441 subd. 11 (b) (1) (2)	ne state This as eyors ' rrection. DING OF OF TO THIS TO ON FOR TATE ed for escope	
	May 4, 2017 at 4:4 considered C1's fa queried why the sta	executive Director (ED-A) on 5 p.m. revealed ED-A III a reportable event. When the agency was not contacted fing C1's fall, ED-A stated the				

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		H21386	B. WING		1	6/2017
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
WILDFLO	OWER LODGE		CK OAKS LA ROVE, MN 5			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
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0 805	Continued From pa	age 10	0 805			
		after every fall, but then added mediately report the incident				
	because they were	taking care of the client and				
		ation, but that "Once we were elves a little bit, I told (RN-C)			1	
	that we need to cal	I and report this." ED-A stated				
		the requirements for reporting. till did not know how the client				
	got through the doo	or. ED-A stated the facility				
	made a vulnerable adult report as soon as they were able to gather all of the needed information,					
	but ED-A acknowle	edged there was an error in the				
	timing of the report					
		vulnerable adult reporting			:	
		requested; the licensee ed document titled, "Vulnerable				
		nal Article." The document				
		yees are considered mandated mandated reporters must				
		ey have reason to believe that inancial exploitation of a				
	vulnerable adult ha	s occurred. The document				
		the failure to provide food, nedical care and or supervision.				
	S.Saming, Srionor, III	is a local or a local or out of violotti				
	TIME PERIOD FO	R CORRECTION: Seven (7)				
	days	. ,				
0 865	144A.4791. Subd.	9(a-e) Service Plan,	0 865		-	
SS=L						į
	revisions to service	lan, implementation, and e plan. (a) No later than 14				
		of services, a home care				
	provider shall finali plan.	ize a current written service				

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Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUF COMPLET	
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NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
WILDFLO	OWER LODGE		CK OAKS LA ROVE, MN 5			
				PROVIDER'S PLAN OF CORRECTI	ON	(VE)
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0 865	Continued From pa	ige 11	0 865			
	include a signature home care provider and be representative door services to be provided. The serviced, based on under subdivisions 7 and information to the oprovider's fee for services and the Ombudsman for (c) The home care	n and any revisions must or other authentication by the by the client or the client's umenting agreement on the lice plan must be revised, if client review or reassessment 8. The provider must provide client about changes to the d how to contact the Office of or Long-Term Care. provider must implement and a required by the current				
	must be entered in	n and revised service plan to the client's record, including in a client's fees when				
,		home care services must be rrent written service plan.				
	by: Based on observareview, the license clients (C1, C2, C4 and C11) received current service plaindicated the client unit, but the licens	tion, interview, and document te failed to ensure ten of eleven 4, C5, C6, C7, C8, C9, C10, services as directed by the an, when the service plan ts would be provided a secure ee failed to ensure the unit was er interventions were in place to		Minnesota Department of Health documenting the State Licensing Correction Orders using federal stag numbers have been assigne Minnesota State Statutes for Hor Providers. The assigned tag nur appears in the far left column enterity Tag." The state Statute nu	software. d to ne Care nber titled "ID	·

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE S COMPL	
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0 865	ensure the safety of This practice result violation that results or death), and is iss (when problems are systemic failure that potential to affect a clients). The finding Medical record reviwith diagnoses that vascular disease, a plan, dated Novem required a secured assessment dated, C1 was vulnerable environment and 2. Review of a docum Report, dated Jan found by staff at the stairwell at 4:30 p.r side with his/her whis side. The report into notified about the cre-opened and shud door at the time of watch door, ensuring Review of an untitle 23, 2017, signed be the Wolf unit was rentry, and staff reput door would stick. The maintenance person locking every other was not making directions.	f the clients. ed in a level four violation (a in serious injury, impairment, sued at a widespread scope in pervasive or represent a at thas affected or has the large portion or all of the included dementia, cerebral and psychosis. C1's service ber 28, 2016, indicated C1 unit. C1's vulnerability November 28, 2016, indicated C1 unit. C1's vulnerability November 28, 2016, indicated to falls and required a safe 4-hour memory care. The entitled "Resident Incident uary 19, 2017 revealed C1 was in its first landing of a back in to be laying on his/her left incelchair tipped over on its dicated maintenance had been loor not locking unless it was to the incident to inform staff to		the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the survifindings is the Time Period for Complete Disregard The Fourth Column which States, "Provider's Plan Correction." This applies federal deficiencies only will appear on Each Page. There is no requirement is used tracking purposes and reflects the and level issued pursuant to 1441 subd. 11 (b) (1) (2)	cies" s the ne state l'This as eyors ' rrection. DING OF TO TO THIS TO ON FOR TATE ed for e scope	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
WILDFLO	OWER LODGE		CK OAKS LA ROVE, MN 5	ANE NORTH			
(VA) ID	STIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
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0 865	Continued From pa	age 13	0 865				
	Investigation for inc ULP-G, indicated the always closed, but	ted document titled "Internal cident for C1", written by ne door on Wolf unit was was not secure. 's service request record,					
	dated January 4, 2 maintenance was p	016 indicated a request for placed by housekeeping for a regarding a stripped magnet.					
	dated September 1 maintenance was p	's service request record, 13, 2016 indicated a request for placed by housekeeping for a arding a key pad sticking off					
	dated January 19, maintenance was p	's service request record, 2017 indicated a request for placed by a resident care f unit door, regarding the door ly.					
	2017, revealed C1 January 19, 2017, designed to be sec The door was inter opened after enter security system. To known by employe time, that the door therefore was not sindicated C1 had re	report, dated January 24, was able to gain access on to a stairwell, via a door cured by a coded lock system. Inded to only be able to be ing a multi-digit code into the he police report indicated it was es, for an extended period of was not properly latching and secure. The police report also made multiple previous and exit through the door, prior curring.					
	2017, revealed C1 was pneumonia du	psy report dated March 24, 's immediate cause of death ue to or as a consequence of e to or as a consequence of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		-		С		
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NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
WILDFLO	OWER LODGE	9251 BLA MAPLE GI	ANE NORTH			
0(4) 10	SHWWARYSTA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
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	blunt force injuries from the fall on January 19, 2017.					
	Physician (PCP-K) PCP-K stated C1 revery advanced dem An interview with unon May 10, 2017 at been aware of the Wolf unit door for othe malfunction of the malfunction of the malfunction of the mand locked. Unultiple verbal required, but was to director there was done with the door demonstrated the reverse advanced the restriction of the was to director there was done with the door demonstrated the reverse advanced the restriction of the was to director there was done with the door demonstrated the reverse advanced to the reverse advanced to the reverse was the was to director there was done with the door demonstrated the reverse advanced to the reverse was the w	nlicensed personnel (ULP-H): 3:21 p.m. revealed s/he has security malfunction of the ver three years. ULP-H stated the door was very stressful, as ry to check the security of the hen working to ensure it ULP-H stated s/he made uests to have the door old by the former maintenance nothing more that could be uLP-H stated s/he malfunction on one occasion to				
	MD-D stated the do stated s/he demon the door "clicked," by pushing on it, as through the door w ULP-H stated there would not lock project.	nce director (MD-D), when cor was working fine. ULP-H strated to MD-D that even if it was possible to open it just and MD-D was able to push right hich had appeared secured. We were times when the door perly, and the alarm system				
	An interview with u on May 30, 2017 a aware the Wolf do ULP-G stated the c sound, as though i would not actually pull on the door fro secure. ULP-G sta	nlicensed personnel (ULP-G) t 1:20 p.m. revealed s/he was or had problems for years. door would make a clicking t automatically locked, but it be locked. Staff would have to m inside the unit to get it to ted staff tended to forget to door, and stated s/he				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		H21386			1 05/20	0/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WILDFLO	OWER LODGE		CK OAKS LA			
			ROVE, MN 5		ON	
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0 865	Continued From pa	ae 15	0 865			
	•					
	suspected somethi	ng would happen as a result.				
	on May 10, 2017 at aware the Wolf dod years. ULP-F stated automatically lock, system to the door alert staff the door staff would need to to make it secure. I residents in the pas prompting nursing ULP-F stated staff orders by calling to	nlicensed personnel (ULP-F) at 4:01 p.m. revealed s/he was or was not in working order for d the door was supposed to but it did not, and the alarm was non-functional and did not was not locked. ULP-F stated physically shut the door twice JLP-F stated two other st three years got out that door, to be notified immediately. were instructed to place work the reception desk, but frequent changes to the staff sk.				
	(LPN-E) on May 4, s/he was aware of properly for over a conversations with director about it. LF maintenance direct could be done abowas an occurrence had been able to gapproximately thre fall. LPN-E stated rknowledge, to rectifollowing this previous/he gave multiple director (ED-A) afted door from other stas/he would look int door is not the only history of security level door in the Market and the security plevel door in t	icensed Practical Nurse 2017 at 4:10 p.m. revealed the Wolf door not locking year, and stated s/he had the former maintenance PN-E indicated the former for said there was nothing that the door. LPN-E stated there with a different client, who et through the door to to six months prior to C1's nothing was done, to his/her fy the situation with the door ous occurrence. LPN-E stated verbal reports to the executive for receiving concerns about the aff, and ED-A's response was to it. LPN-E added the Wolf of door in the facility with a problems, stating the lower toose unit has a magnet that no E stated management installed				

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 0 865 0 865 Continued From page 16 a dead bolt lock to that door after a resident made his/her way through it and was found between the Moose door and an outside door. An interview with Registered Nurse (RN-C) on May 4, 2017 at 2:48 p.m. revealed s/he was aware of issues with the Wolf door sticking around the years 2013 or 2014, because the former director of nursing made it known to everyone to closely monitor the door. RN-C denied awareness of on-going concerns with that door. An interview with Maintenance Director (MD-D) on May 4, 2017 at 1:18 p.m. revealed s/he was not immediately made aware of the incident involving C1, but rather, was informed by the facility receptionist at approximately 10:00 a.m. the following day. Upon inspection, MD-D stated the door was catching about every other time due to an issue with the magnet plate. MD-D stated s/he lowered the magnet plate to fix the problem. MD-D stated s/he knew of on-going issues for at least a year or more with the door. MD-D stated the maintenance director before him/her could not figure it out, as weather changes often cause the building to shift. MD-D stated the process for submitting maintenance tickets at the time was for staff to go through the receptionist to write them up and have the tickets delivered to a slot. Now, MD-D said, an electronic system is used. An interview with Executive Director (ED-A) on May 4, 2017 at 4:45 p.m. revealed s/he knew the Wolf door had issues, referring to them as "seasonal changes" which made the door shrink

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and swell. ED-A stated s/he was not made aware of a "serious issue" with the door locking. When asked how the door could secure properly if it is stuck, ED-A stated, "you would have to push it"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` .	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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H213		H21386	B. WING		05/26/	2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
WILDFLOWER LODGE 9251 BLACK OAKS LANE NORTH						
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0 865	Continued From pa	ge 17	0 865			
0 865	and that s/he has b so. ED-A stated the closed all of the was stated s/he was tole three times in the la any other door to b maintenance right a stated two other se facility had dead-be queried why deadb security system we explained that the extra step to make indicated there was making frequent elable to exit the door the facility was unaclient was able to add the deadbolts the deadbolts were doors could be pus not know and had push a door open to locked. ED-A then LPN-E about being thought to be secured installation. ED-A sinceded to impleme assessment of the were secured proposed interview with a far 2017 at 12:51 p.m. staff to come to the C1's fall. FM-J staff door C1 went throught thought thought thought to the secured proposed in the come to the C1's fall. FM-J staff door C1 went throught thought thought the secured proposed in the come to the C1's fall. FM-J staff door C1 went throught the come to the C1's fall. FM-J staff door C1 went throught the come to the C1's fall. FM-J staff door C1 went throught the come to the C1's fall. FM-J staff door C1 went throught the come to the C1's fall. FM-J staff door C1 went throught the come to the C1's fall.	een able to secure it by doing at if staff did not get the door y, it would not lock. ED-A d about the sticking issues ast year, and said if s/he found e sticking s/he would call away to have it looked at. ED-A cured and coded doors in the olt locks added to them. When olts would be necessary if the re fully functioning, ED-A deadbolt adds an "intentional sure that it's locked." ED-A is a client that was previously openent attempts, who was ars five or six times, and since able to determine how that open the doors, they decided to to some doors. When asked if there because otherwise the shed open, ED-A stated she did never personally been able to that was supposed to be stated s/he was informed by a able to push through a door re prior to the deadbolt stated she believed the facility ent a more frequent doors to determine if they				
	his/her spouse too door, indicating sig	k photographs of the Wolf gnage was in place on the day				
	of the fall warning	staff to ensure the door was	<u> </u>			

PRINTED: 06/30/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: С B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 0 865 0 865 Continued From page 18 secure. Review of photographs provided by Family Member (FM-J) via e-mail correspondence on May 9, 2017 revealed two signs were posted to the Wolf door on the day of the fall and read, "Stop, wait for the click, 20 second delay for the lock to engage" and "Please double check that door is locked before you walk away. Door does not like to latch. Shut the door twice. Thank you, Management." Observations made during the on-site visit on May 4, 2017 from 8:15 a.m. to 5:40 p.m. revealed a paper sign hanging on the Wolf door that read, "Please double check that door is locked before vou walk away. Door does not like to latch. Shut door twice. Thank you, Management." The door was unable to be accessed without entering a code. An alarm sounded after approximately thirty seconds of holding the door open. C2's medical record was reviewed. C2 admitted with diagnoses that included dementia, Parkinson's Disease, and muscle weakness. C2's service plan, dated January 6, 2017 indicated C2 required a secured unit. C4's medical record was reviewed. C4 admitted with diagnoses that included Alzheimer's disease and rheumatoid arthritis. C4's service plan, dated December 12, 2016 indicated C4 required a

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secured unit.

secured unit.

C5's medical record was reviewed. C5 admitted with diagnoses that included pseudo-dementia and osteoarthritis. C5's service plan, dated November 28, 2016 indicated C5 required a

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 865 Continued From page 19 0 865 C6's medical record was reviewed. C6 admitted with diagnoses that included dementia and major depression. C6's service plan, dated November 22, 2016 indicated C6 required a secured unit. C7's medical record was reviewed. C7 admitted with diagnosis that included Alzheimer's disease, dementia, anxiety, and depression. C7's service plan, dated December 31, 2016 indicated C7 required a secured unit. C8's medical record was reviewed. C8 admitted with diagnosis that included Alzheimer's disease, dementia, and depression. C8's service plan, dated November 29, 2016 indicated C8 required a secured unit. C9's medical record was reviewed. C9 admitted with diagnosis that included dementia, major depressive disorder, and anxiety. C9's service plan, dated February 28, 2017 indicated C9 required a secured unit. C10's medical record was reviewed. C10 admitted with diagnosis that included vertigo and unsteady gait. C10's service plan, dated November 20, 2016 indicated C10 required a secured unit. C11's medical record was reviewed, C11 admitted with diagnosis that included Alzheimer's disease. schizoaffective disorder, altered mental status, anxiety, and depression. C11's service plan, dated January 18/, 2017 indicated C11 required a secured unit.

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Observations during the on-site visit on May 4, 2017 from 8:15 a.m. to 5:40 p.m. revealed the facility's floor plan includes multiple sets of stairs

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: A. BUILDING:	(X3) DATE SURVEY COMPLETED
	C
H21386 B. WING	05/26/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
WILDFLOWER LODGE 9251 BLACK OAKS LANE NORTH MAPLE GROVE, MN 55311	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S F PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC' TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETE CED TO THE APPROPRIATE DATE EFICIENCY)
throughout the common areas, with decorative wooden gates at the top of each stairway. The gates are intended to be secured by latches placed on the stair side of the gate at approximately 25° above floor level. The decorative nature of the gates, however, creates openings large enough for a hand or arm to fit through, potentially allowing access to the latch and therefore, access to the stairwell. The gate between Bear and Buffalo units, an area of seven stairs, was observed to be unlatched and left open. The gates do not have auto-closing mechanisms attached to them. An interview with Licensed Practical Nurse (LPN-E) on May 4, 2017 at 4:10 p.m. revealed it is a common occurrence for gates to be left open. LPN-E verified the gates within the community are a safety risk and added s/he has spoken to ED-A about concerns. LPN-E stated there was nothing which would have prevented a client in a wheelchair from falling down the stairs between the Bear and Buffalo units during the time it was observed to be open. An interview with Registered Nurse (RN-C) on May 4, 2017 at 2:48 p.m. revealed some clients use the gates to gain access to other areas of the building. RN-C stated gate safety has been brought up during supervisor meetings and staff are supposed to be encouraged to close them if observed open. An interview with Director of Nursing (DON-B) on May 4, 2017 at 3:50 p.m. revealed s/he voiced concern and surprise to ED-A regarding the gates prior to his/her hire date in April 2017 during an interview. DON-B stated ED-A discussed possibly replacing the gates at that time. DON-B added	

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PRINTED: 06/30/2017 FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 865 Continued From page 21 0 865 do so. An interview with Maintenance Director (MD-D) on May 4, 2017 at 1:18 p.m. revealed as a group, staff are attempting to come up with a solution to replace the gates, MD-D stated LPN-E brought a safety concern to a supervisor meeting approximately one month ago. An interview with Executive Director (ED-A) on May 4, 2017 at 4:45 p.m. revealed the intention of the gates within the facility is to remind people they are entering an area with stairs and a different elevation. ED-A verified staff often leave the gates open and need frequent reminders to close them as the gates do not have an auto-close mechanism. ED-A verified the gates have openings large enough to reach through. When queried what would prevent a client from unlatching a gate and falling down the steps in a wheelchair, ED-A stated, "I don't know the answer to that, other than the staff. If we have someone who is that able to manipulate things in a wheelchair and get around that, there would need to be an intervention in place to make sure that they aren't going toward the gate or they're not able to manipulate the latch." When asked how the clients are assessed for ability, ED-A verified nursing does not assess for gate safety. A policy titled Housing and Assisted Living Community Residence and Service Agreement dated, April 1, 2017 states on page seven a basic

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service provided under the service plan is maintenance of common areas and grounds at the community. On page eight, the policy states all services provided by the community will be in

accordance with the client's care plan as determined by the client, the client's treating physician, and by the client's personal desires if

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _____ C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 0 865 0 865 Continued From page 22 consistent with medical advice or keeping with a negotiated risk agreement, if necessary. TIME PERIOD FOR CORRECTION: Seven (7) days 02015 02015 626.557, Subd. 3 Timing of Report SS=H Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the

as described above.

provisions of this section may voluntarily report

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 02015 02015 Continued From page 23 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced Minnesota Department of Health is Based on interview and document review, the documenting the State Licensing facility failed to report a significant fall with injury Correction Orders using federal software. to the state agency for one of one client (C1) Tag numbers have been assigned to reviewed until five days later and after the client Minnesota State Statutes for Home Care died. Providers. The assigned tag number appears in the far left column entitled "ID This practice resulted in a level three violation (a Prefix Tag." The state Statute number and violation that harmed a client's health or safety,

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not including serious injury, impairment, or death,

or a violation that has the potential to lead to

the corresponding text of the state Statute

out of compliance is listed in the

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING H21386 05/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 02015 Continued From page 24 02015 "Summary Statement of Deficiencies" serious injury, impairment, or death) and is issued column. This column also includes the at a pattern scope (when more than a limited findings which are in violation of the state number of clients are affected more than a limited number of staff are involved, or the situation has requirement after the statement. "This occurred repeatedly but is not found to be Minnesota requirement is not met as pervasive. The findings include: evidenced by." Following the surveyors ' findings is the Time Period for Correction. Medical record review revealed C1 was admitted with diagnoses that included dementia, cerebral PLEASE DISREGARD THE HEADING OF vascular disease, and psychosis. C1's service THE FOURTH COLUMN WHICH plan, dated November 28, 2016, indicated C1 STATES, "PROVIDER'S PLAN OF required a secured unit. C1's vulnerability CORRECTION." THIS APPLIES TO assessment, dated November 28, 2016 indicated FEDERAL DEFICIENCIES ONLY. THIS C1 was vulnerable to falls, requiring a safe WILL APPEAR ON EACH PAGE. environment and 24-hour memory care. THERE IS NO REQUIREMENT TO Review of a document titled. "Resident Incident SUBMIT A PLAN OF CORRECTION FOR Report," dated January 19, 2017 revealed C1 was **VIOLATIONS OF MINNESOTA STATE** found by staff at 4:30 p.m., at the first landing of a STATUTES. back stairwell, laving on his/her left side with the wheelchair tipped over on its side. The letter in the left column is used for tracking purposes and reflects the scope Review of a police report dated January 24, 2017, and level issued pursuant to 1441,474 revealed C1 was able to gain access on January subd. 11 (b) (1) (2) 19, 2017, to a stairwell via a door designed to be secured by a coded lock system. The door was intended to only be able to be opened after entering a multi-digit code into the security system. The police report indicated it was known by employees, for an extended period, that the door was not properly latching and therefore, was not secure. The police report also indicated C1 had made multiple previous attempts to open and exit through the door prior to the incident occurring. An interview with Executive Director (ED-A) on May 4, 2017 at 4:45 p.m. revealed ED-A

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considered C1's fall a reportable event. When queried why the state agency was not contacted

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C B. WING 05/26/2017 H21386 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9251 BLACK OAKS LANE NORTH WILDFLOWER LODGE MAPLE GROVE, MN 55311 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 02015 02015 Continued From page 25 immediately following C1's fall, ED-A stated the facility did not call after every fall, but then added that they did not immediately report the incident because they were taking care of the client and addressing the situation, but that "Once we were able to round ourselves a little bit, I told (RN-C) that we need to call and report this." ED-A stated s/he was aware of the requirements for reporting. ED-A stated s/he still did not know how the client got through the door. ED-A stated the facility made a vulnerable adult report as soon as they were able to gather all of the needed information, but ED-A acknowledged there was an error in the timing of the report. A policy regarding vulnerable adult reporting requirements was requested; the licensee provided an undated document titled, "Vulnerable Adult, An Educational Article." The document indicates all employees are considered mandated reporters and that mandated reporters must make a report if they have reason to believe that abuse, neglect or financial exploitation of a vulnerable adult has occurred. The document defines neglect as the failure to provide food, clothing, shelter, medical care and or supervision. TIME PERIOD FOR CORRECTION: Seven (7) days

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