MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Wildflower Lodge

Facility Address:
9251 Black Oaks Lane North

Facility City:
Maple Grove

State: Minnesota | **ZIP:** 55311 | **County:** Hennepin

Report Number:
HL21386004 and HL21386005

Date of Visit:
May 4, 2017

Time of Visit:
8:15 a.m. to 5:40 p.m.

Date Concluded:
July 7, 2017

Investigator's Name and Title:
Casey DeVries, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

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

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.

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

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 ☒ Neglect ☐ Financial Exploitation

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

Mitigating Factors:

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

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

The facility 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 for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

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

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Medical Examiner Records
- [x] Death Certificate
- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility In-service Records
- [x] Facility Policies and Procedures
- [x] Other, specify: Maintenance log, Complaint log, Safety committee

Number of additional resident(s) reviewed: Ten

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Resident deceased

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact reporter, attempts were made on:

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

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

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

○ Yes ◉ No ○ N/A Specify: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ Cleanliness

☒ Safety Issues

☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A
Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A
Were photographs taken: ◉ Yes ◯ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Hennepin County Medical Examiners

Maple Grove Police Department

Hennepin County Attorney

Maple Grove City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21386	A. BUILDING: _____ B. WING _____	C 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

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On May 4, 2017, a complaint investigation was initiated to investigate complaints #HL21386004 and HL21386005. At the time of the survey, there were forty clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. 144A.474 subd. 11 (b) (1) and (2).	
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure 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 found by staff at the first landing of a back	0 325		

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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, dated January 19, 2017 indicated a request for maintenance was placed by a resident care assistant for a Wolf unit door, regarding the door not latching properly.	0 325		

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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 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	0 325		

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0 325	Continued From page 4 MD-D stated the door was working fine. ULP-H stated s/he demonstrated to MD-D that even if the door "clicked," it was possible to open it just by pushing on it, and MD-D was able to push right through the door which had appeared secured. ULP-H stated there were times when the door would not lock properly, and the alarm system would not sound to alert staff of the issue. An interview with unlicensed personnel (ULP-G) on May 30, 2017 at 1:20 p.m. revealed s/he was aware the Wolf door had problems for years. ULP-G stated the door would make a clicking sound, as though it automatically locked, but it would not actually be locked. Staff would have to pull on the door from inside the unit to get it to secure. ULP-G stated staff tended to forget to double check the door, and stated s/he suspected something would happen as a result. An interview with unlicensed personnel (ULP-F) on May 10, 2017 at 4:01 p.m. revealed s/he was aware the Wolf door was not in working order for years. ULP-F stated the door was supposed to automatically lock, but it did not, and the alarm system to the door was non-functional and did not alert staff the door was not locked. ULP-F stated staff would need to physically shut the door twice to make it secure. ULP-F stated two other residents in the past three years got out that door, prompting nursing to be notified immediately. ULP-F stated staff were instructed to place work orders by calling to the reception desk, but added, there were frequent changes to the staff at the reception desk. An interview with Licensed Practical Nurse (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	0 325		

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0 325	Continued From page 5 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 s/he lowered the magnet plate to fix the problem.	0 325		

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0 325	Continued From page 6 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 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" and that s/he has been able to secure it by doing so. ED-A stated that if staff did not get the door closed all of the way, it would not lock. ED-A stated s/he was told about the sticking issues three times in the last year, and said if s/he found any other door to be sticking s/he would call maintenance right away to have it looked at. ED-A stated two other secured and coded doors in the facility had dead-bolt locks added to them. When queried why deadbolts would be necessary if the security system were fully functioning, ED-A explained that the deadbolt adds an "intentional extra step to make sure that it's locked." ED-A indicated there was a client that was previously making frequent elopement attempts, who was able to exit the doors five or six times, and since the facility was unable to determine how that client was able to open the doors, they decided to add the deadbolts to some doors. When asked if the deadbolts were there because otherwise the doors could be pushed open, ED-A stated she did not know and had never personally been able to	0 325		

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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 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 seconds of holding the door open.	0 325		

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	H21386	A. BUILDING: _____ B. WING _____	C 05/26/2017

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WILDFLOWER LODGE	9251 BLACK OAKS LANE NORTH MAPLE GROVE, MN 55311

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0 325	Continued From page 8 A policy regarding vulnerable adults 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. A policy from the Emergency Handbook table of contents titled, Life Safety System Failure was requested. The licensee did not provide this policy. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		
0 805 SS=H	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report a significant fall with injury to the state agency for one of one client (C1) reviewed until five days later, and after the client died. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is issued	0 805	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies"	

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0 805	Continued From page 9 at a pattern scope (when more than a limited number of clients are affected more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). 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, requiring a safe environment and 24-hour memory care. Review of a document titled, "Resident Incident Report," dated January 19, 2017 revealed C1 was found by staff at 4:30 p.m., at the first landing of a back stairwell, laying on his/her left side with the wheelchair tipped over on its side. 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, 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 considered C1's fall a reportable event. When queried why the state agency was not contacted immediately following C1's fall, ED-A stated the	0 805	column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	

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0 805	Continued From page 10 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	0 805		
0 865 SS=L	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan.	0 865		

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0 865	Continued From page 11 (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure ten of eleven clients (C1, C2, C4, C5, C6, C7, C8, C9, C10, and C11) received services as directed by the current service plan, when the service plan indicated the clients would be provided a secure unit, but the licensee failed to ensure the unit was secure or that other interventions were in place to	0 865	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and	

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0 865	Continued From page 12 ensure the safety of the clients. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: 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 found by staff at the first landing of a back 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.	0 865	the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	

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0 865	Continued From page 13 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, dated January 19, 2017 indicated a request for maintenance was placed by a resident care assistant for a Wolf unit door, regarding the door not latching properly. 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	0 865		

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0 865	Continued From page 14 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 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 MD-D stated the door was working fine. ULP-H stated s/he demonstrated to MD-D that even if the door "clicked," it was possible to open it just by pushing on it, and MD-D was able to push right through the door which had appeared secured. ULP-H stated there were times when the door would not lock properly, and the alarm system would not sound to alert staff of the issue. An interview with unlicensed personnel (ULP-G) on May 30, 2017 at 1:20 p.m. revealed s/he was aware the Wolf door had problems for years. ULP-G stated the door would make a clicking sound, as though it automatically locked, but it would not actually be locked. Staff would have to pull on the door from inside the unit to get it to secure. ULP-G stated staff tended to forget to double check the door, and stated s/he	0 865		

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0 865	Continued From page 15 suspected something would happen as a result. An interview with unlicensed personnel (ULP-F) on May 10, 2017 at 4:01 p.m. revealed s/he was aware the Wolf door was not in working order for years. ULP-F stated the door was supposed to automatically lock, but it did not, and the alarm system to the door was non-functional and did not alert staff the door was not locked. ULP-F stated staff would need to physically shut the door twice to make it secure. ULP-F stated two other residents in the past three years got out that door, prompting nursing to be notified immediately. ULP-F stated staff were instructed to place work orders by calling to the reception desk, but added, there were frequent changes to the staff at the reception desk. An interview with Licensed Practical Nurse (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 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	0 865		

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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 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"	0 865		

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0 865	Continued From page 17 and that s/he has been able to secure it by doing so. ED-A stated that if staff did not get the door closed all of the way, it would not lock. ED-A stated s/he was told about the sticking issues three times in the last year, and said if s/he found any other door to be sticking s/he would call maintenance right away to have it looked at. ED-A stated two other secured and coded doors in the facility had dead-bolt locks added to them. When queried why deadbolts would be necessary if the security system were fully functioning, ED-A explained that the deadbolt adds an "intentional extra step to make sure that it's locked." ED-A indicated there was a client that was previously making frequent elopement attempts, who was able to exit the doors five or six times, and since the facility was unable to determine how that client was able to open the doors, they decided to add the deadbolts to some doors. When asked if the deadbolts were there because otherwise the doors could be pushed open, ED-A stated she did not know and had never personally been able to 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	0 865		

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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 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 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 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 secured unit.	0 865		

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0 865	Continued From page 19 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. 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	0 865		

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	H21386	A. BUILDING: _____ B. WING _____	C 05/26/2017

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0 865	Continued From page 20 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 s/he is unaware if any action has been taken to	0 865		

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0 865	Continued From page 21 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 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	0 865		

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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	0 865		
02015 SS=H	626.557, Subd. 3 Timing of Report 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 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	02015		

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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 by: Based on interview and document review, the facility failed to report a significant fall with injury to the state agency for one of one client (C1) reviewed until five days later and after the client died. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	02015	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the	

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02015	Continued From page 24 serious injury, impairment, or death) and is issued at a pattern scope (when more than a limited number of clients are affected more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive. 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, requiring a safe environment and 24-hour memory care. Review of a document titled, "Resident Incident Report," dated January 19, 2017 revealed C1 was found by staff at 4:30 p.m., at the first landing of a back stairwell, laying on his/her left side with the wheelchair tipped over on its side. 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, 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 considered C1's fall a reportable event. When queried why the state agency was not contacted	02015	"Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	

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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	02015		