MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Heritage House of Milaca

Facility Address:
115 9th Street Northwest Suite 120

Facility City:
Milaca

State:	**ZIP:**	**County:**
Minnesota	56353	Mille Lacs

Report Number:
HL23743006 & HL23743007

Date of Visit:
November 1 & 2, 2016

Time of Visit:
9:30 a.m.- 3:15 p.m.
9:30 a.m. - 4:00 p.m.

Date Concluded:
February 3, 2017

Investigator's Name and Title:
Rhylee Gilb, RN, Special Investigator

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a resident was not supervised when the resident had oxygen and an oxygen mask on, lit up a cigarette and sustained burns to the side of the face and lungs. Staff extinguished the fire and called for emergency medical services. The resident was transferred to a hospital and then transferred to a burn unit at a second hospital.

☒ 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 staff failed to provide adequate supervision, and a client lit a cigarette, while using liquid oxygen, and was burned.

The client had diagnoses that included chronic obstructive pulmonary disease and schizophrenia. The client received home care services and required assistance with oxygen management. The client was a known smoker; however, the risks related to smoking with oxygen were not assessed, and the only clear rule from the home care provider was no smoking indoors. The client was mostly compliant with removing the oxygen tank prior to going outside to smoke, but staff were aware the client sometimes smoked outside with the oxygen tank still attached, either turning the flow off or pulling the oxygen tubing away from his/her nose.

On the day of the incident, a staff member assisted the client outside to get fresh air on the patio. The client had his/her liquid oxygen tank attached to the wheelchair and was using a nasal cannula to deliver oxygen with the flow on. The client received a cigarette from another client while on the patio. When the client used the lighter, the oxygen tubing ignited. The client removed the oxygen tubing from his/her nose and walked away from the wheelchair and the oxygen tank. A staff member assisted the client inside through a door furthest from the fire, while another staff member called emergency services and extinguished the fire. The client was given a cold wash cloth to apply to the burns on the side of the face and was transported to the hospital.

The client was transferred to a burn unit to treat his/her injuries. The client had second degree burns to the right side of the face including, the cheek, nose, eyelid, and eyebrow. In addition, the client experienced soot and burn damage to his/her lungs and airway. The client required intubation for two days and a feeding tube for ten days. The client was hospitalized for sixteen days and discharged back to the home care provider with ongoing physical therapy, occupational therapy and speech therapy (for swallowing concerns). The client continued to require ointment treatment to the facial burns.

The client was interviewed while in the hospital. The client remained on tube feedings, was on oxygen, and required treatment of the burns. The client was lethargic, but able to arouse to answer questions. The client stated s/he had forgotten to take off his/her oxygen prior to lighting a cigarette.

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 client's vulnerable adult assessment failed to address the client risk of smoking with oxygen. The home care provider had a smoking assessment completed on the client, but did not indicate if the client understood the smoking policy. There was no written smoking policy, only a mention of "no smoking indoors" in the resident handbook. The handbook did not address safety practices with smoking or designated smoking areas.

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:

Facility Corrective Action:

The facility took the following corrective action(s):

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

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: three

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

Specify: _____

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

○ Yes ◉ No ○ N/A

Specify: the client was hospitalized

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact complainant, 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: three

Interview with staff: ◉ Yes ◯ No ◯ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ◯ No

Total number of staff interviews: six

Physician Interviewed: ◯ Yes ◉ No

Nurse Practitioner Interviewed: ◯ Yes ◉ No

Physician Assistant Interviewed: ◯ Yes ◉ No

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

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:

☒ Use of Equipment

☒ 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

Milaca Police Department

Mille Lacs County Attorney

Milaca City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 16, 2018

Mica Zimmer, Administrator
Heritage House Of Milaca
115 9th St Nw Suite 120
Milaca, MN 56353

RE: Complaint Number HL23743006 and HL23743007

Dear Administrator:

On January 23, 2018 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on November 30, 2016. At this time these correction orders were found corrected.

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

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Mille Lacs County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23743	A. BUILDING: _____ B. WING _____	R-C 01/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF MILACA	115 9TH ST NW SUITE 120 MILACA, MN 56353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments A licensing order follow-up was completed to follow up on correction orders issued related to complaint HL23743006 and HL23743007. Heritage House of Milaca was found in compliance with state regulations.	{0 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 11/1/16 and 11/2/16, a complaint investigation was initiated to investigate complaint #HL23743006 and HL23743007. At the time of the survey, there were 37 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 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 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=K	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 observation, interview, and document review the licensee failed to keep clients safe from maltreatment for two of four clients (C1, C2) reviewed, when C1 was allowed outside with an oxygen tank, lit a cigarette, and sustained second degree burns from the lighter igniting into flames; and the potential for a second occurrence with C2. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was 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: The licensee Resident Handbook address smoking under the Social Activities section and indicated the licensee was a smoke free facility. Smoking is not permitted in the living units or anywhere else inside the building. C1's medical record was reviewed. C1 began receiving services on 4/7/16 and was admitted with diagnoses that included chronic obstructive pulmonary disease, schizophrenia, bi-polar and diabetes. C1's service plan dated 9/7/16 indicated C1 required assistance with oxygen. An oxygen delivery slip indicated oxygen was delivered on 4/6/16 with the prescription of four liters per	0 325		

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0 325	Continued From page 2 minute (LPM) of continuous oxygen. A pre-screening assessment dated 4/6/16 indicated C1 smoked. A Resident Smoking Assessment dated 4/7/16 indicated C1 was safe to smoke outside unsupervised, however "no" was indicated for any additional concerns and oxygen use was not mentioned on the assessment. Also, no response was marked on the assessment for the question regarding whether the resident agreed to follow the smoking rules and smoke in designated areas. An undated Vulnerable Adult Assessment indicated C1 was not vulnerable with unsafe smoking and oxygen use and mentioned C1 left his oxygen tank inside. C1's nurse notes indicated C1 was hospitalized for shortness of breath on 9/12/16 to 9/15/16. On 10/3/16, C1 had a mood change from baseline, and oximeter readings of 62 percent to 79 percent. C1 refused nebulizer treatments and continued to take his oxygen off in order to smoke outside. C1 did agree to be seen in the emergency department and was hospitalized in the intensive care unit. C1 left against medical advice. The hospital had no new medication orders at discharge, but indicated C1 should stop smoking. C1 was seen by the physician assistant on 10/12/16, who recommended the following referrals: sleep study for BiPAP (Bilevel Positive Airway Pressure) use and an appointment with C1's primary physician for a medication review. C1 also requested from staff to start nicotine patches, and a physician order dated 10/12/16 was received to start Nicoderm. C1 requested to delay the start of Nicoderm until 11/1/16 and a physician order dated 10/13/16 indicated that was approved. C1 was seen by his physician on 10/18/16 who recommended C1 to maintain oxygen saturation between 85 and 90 percent and follow up with psychiatry as soon as possible.	0 325		

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0 325	Continued From page 3 A psychiatry appointment was made for 11/11/16. An incident report dated 10/27/16 indicated staff escorted C1, with his oxygen tank in use, onto the patio outside of the dining room. Another client came into the dining room and alerted the licensed practical nurse (LPN) of an incident in which C1's oxygen tank was on fire. C1's nurse note dated 10/27/16 gave further detail that C1 was alert and stated "I forgot to take my oxygen off." There were noted facial burns and singed hair when the registered nurse (RN) assessed him; C1 had already been escorted into the dining room at this point. The RN extinguished the oxygen tank with law enforcement, and emergency services arrived to transport C1 to the hospital. A hospital report dated 10/27/16 to 11/11/26 indicated C1 was transported to a secondary hospital and admitted to the burn unit. C1 was intubated en route to the hospital and experienced partial thickness (second degree) burns to the right side of the face (ear, eye, nose, and cheek). In addition, C1 also experienced soot staining in the trachea and mid thermal injury to the airway from smoke inhalation. Due to airway injury, C1 required tube feedings for nine days, after which he was increased to a soft diet with thickened liquids per evaluation from speech therapy. C1 was discharged back to the licensee on 11/11/16 with previous respiratory status, requiring four LPM of continuous oxygen via nasal cannula. However, C1 continued to require physical therapy, occupational therapy, speech therapy and a psychiatric consult to readjust medications. During an interview with unlicensed staff (ULP)-C on 11/2/16 at 11:30 a.m., ULP-C stated C1 would	0 325		

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0 325	Continued From page 4 usually leave his oxygen tank in the lobby prior to going outside to smoke. However, ULP-C stated C1 had increased breathing difficulties and required his oxygen all the time. ULP-C had seen C1 outside with the oxygen tank smoking before. ULP-C stated C1 required assistance with turning off/on the oxygen flow to the tank. An interview with ULP-D on 11/2/16 at 1:25 p.m., ULP-D stated C1 was supposed to wear his oxygen all time and in the past month had been pretty good about keeping it on. ULP-D also stated C1 required assistance with turning off/on the oxygen flow. On 11/2/16 at 1:40 p.m., ULP-F stated she witnessed the incident with C1 on 10/27/16. ULP-F explained she was in the dining area when there was a sudden commotion and another client said "fire, fire". ULP-F stated she looked out the dining room window and saw smoke and flames, and C1 in his wheelchair. ULP-F stated she saw C1 get up from his wheelchair, walk across the patio, and sit in a patio chair next to the dining room door. ULP-F said she went outside to help C1 get inside, while the LPN arrived. ULP-F described C1's face as black with ash and appearing singed. In addition, ULP-F stated meanwhile the oxygen tank was left by a second dining room door on the ground, tipped over on the side. ULP-F stated she has seen C1 smoke outside with his oxygen tank in the past, and staff helped him turn off the tank. ULP-F stated C1 did have cigarettes the day of the incident but also had been known to smoke other people's cigarette butts or borrow from other residents. ULP-F added a sign that states "No oxygen tanks beyond this point" on the dining room door was hung up on 11/1/16.	0 325		

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0 325	Continued From page 5 C1 was interviewed on 11/3/16 at 12:00 p.m. while admitted at the hospital. C1 had visible burns to the right eyebrow (eyebrow hair burned off), right upper eyelid, right side of nose, and right cheek, that were treated with ointment. C1 had a nasal gastric tube placed for tube feedings and received oxygen by nasal cannula. C1 was drowsy, but able to arouse for a few questions. C1 stated staff usually helped him with his oxygen (turning the tank on/off), but he could not remember if he asked for help from staff on the day of the incident. C1 stated he borrowed a cigarette from another client (C4) while outside on the patio. C1 explained he still had the nasal cannula in his nose and the oxygen on when he lit the lighter to light the cigarette. C1 stated he remembered his face lit on fire, he removed the nasal cannula tubing, got up from his wheelchair, and walked away from the fire. C2's medical record was reviewed. C2 was admitted with diagnoses that included chronic obstructive pulmonary diseas and nicotine dependence. C2's service plan 3/1/16 did not indicate assistance with oxygen. A Resident Smoking Assessment dated 3/1/16 indicated C1 was safe to smoke unsupervised, however the question as to whether the resident agreed to follow smoking rules was left unanswered. A Vulnerable Adult Assessment indicated smoking was a vulnerability and the intervention was the client was educated to take off her oxygen when smoking. A Device Assessment dated 3/3/16 indicated C2 was able to use her oxygen equipment independently. Observations were completed on 11/1/16 and 11/2/16. On 11/1/16, the patio outside the dining room was observed. The patio had two entrances approximately fifty feet from one another both on	0 325		

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0 325	Continued From page 6 the same outside wall from the dining room. There were no designated smoking area signs on the patio. On 11/2/16 a new sign was posted on the patio entrance door that stated "No oxygen tanks beyond this point." ULP-C was observed performing oxygen assistance for C2. ULP-C filled the portable liquid oxygen tanks and stated C2 was unable to do so, however C2 was able to remove the portable oxygen tank and turn the oxygen flow on/off. C2 and C4 were both observed smoking outside on the patio throughout the day without oxygen. C2 smoked under an open tent with an ash tray. C2 was interviewed on 11/2/16 at 11:00 a.m. C2 stated until C1's incident she had brought her oxygen tank outside while smoking. C2 explained the "no oxygen use" signs were hung up the previous day. During an interview with ULP-C on 11/2/16 at 11:30 a.m., ULP-C stated C2 had always smoked outside with her oxygen tank prior to C1's incident. ULP-C explained C2 always turned off the tank herself prior to smoking, but still left it attached to her wheelchair. ULP-C stated that now the licensee is not allowing any oxygen tanks outside anymore. During an interview with ULP-D on 11/2/16 at 1:25 p.m., ULP-D stated C2 went outside all the time with her oxygen tank. ULP-D stated sometimes C2 would turn off the tank on her own, other times C2 would just pull the nasal cannula down around her neck and kept the tank on. ULP-D added, staff told her she should not be smoking with her oxygen, but C2 refused removing the oxygen tank and stated she was fine.	0 325		

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0 325	Continued From page 7 On 11/2/16 at 1:40 p.m. ULP-F also stated she had seen C2 smoke outside with her oxygen tank on multiple occasions. During an interview with LPN-B on 11/2/16 at 2:00 p.m., LPN-B stated C2 would go outside with her oxygen tank, turn it off and smoke. LPN-B stated when C2 was told not smoke with her oxygen tank, C2 would be non-compliant. Also, LPN-B explained the patio was not the designated smoking area, however the clients who smoked always went there. Therefore, LPN-B stated the licensee put a tent outside for the clients to use in the winter. LPN-B stated she did not know who would enforce the policies or rules if clients are non-compliant. During an interview with RN-A on 11/2/16 at 2:20 p.m., RN-A stated she had just started in her position 10/3/16 and was still getting to know clients. RN-A stated she was unsure if she had seen any clients outside smoking with oxygen tanks. In addition, RN-A explained there was no smoking policy, only the mention of "no smoking inside the building" in the resident handbook. RN-A added that since the incident with C1, the licensee had placed signs stating no oxygen use beyond this point and a shelter outside for clients to use while smoking, which allows staff to monitor them more closely. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 325		
0 810 SS=H	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and	0 810		

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	H23743	A. BUILDING: _____ B. WING _____	C 11/30/2016

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0 810	Continued From page 8 implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to appropriately identify vulnerabilities and provide a maltreatment prevention plan for three of four clients (C1, C2, C4) reviewed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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: C1's medical record was reviewed. C1 began receiving services on 4/7/16 and was admitted with diagnoses that included chronic obstructive	0 810		

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0 810	Continued From page 9 pulmonary disease, schizophrenia, bi-polar and diabetes. C1's service plan dated 9/7/16 indicated C1 required assistance with oxygen. An oxygen delivery slip indicated oxygen was delivered on 4/6/16 with the prescription of four liters per minute (LPM) of continuous oxygen. A pre-screening assessment dated 4/6/16 indicated C1 smoked. A Resident Smoking Assessment dated 4/7/16 indicated C1 was safe to smoke outside unsupervised, however "no" was indicated for any additional concerns and oxygen use was not mentioned on the assessment. Also, no response was marked on the assessment for the question regarding whether the resident agreed to follow the smoking rules and smoke in designated areas. An undated Vulnerable Adult Assessment indicated C1 was not vulnerable with unsafe smoking and oxygen use and mentioned C1 left his oxygen tank inside. An incident report, dated 10/27/16, indicated C1 had caught on fire while smoking with his oxygen in use. During an interview with unlicensed staff (ULP)-C on 11/2/16 at 11:30 a.m., ULP-C stated C1 would usually leave his oxygen tank in the lobby prior to going outside to smoke. However, ULP-C stated C1 had increased breathing difficulties, and required his oxygen all the time. ULP-C had seen C1 outside with the oxygen tank smoking before. ULP-C stated C1 required assistance with turning off/on the oxygen flow to the tank. During an interview with ULP-D on 11/2/16 at 1:25 p.m., ULP-D stated C1 was supposed to wear his oxygen all time and in the past month had been pretty good about keeping it on. ULP-D also stated C1 required assistance with turning off/on the oxygen flow.	0 810		

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0 810	Continued From page 10 On 11/2/16 at 1:40 p.m., ULP-F stated she has seen C1 smoke outside with his oxygen tank in the past and staff helped him turn off the tank. ULP-F stated C1 did have cigarettes the day of the incident but also had been known to smoke other people's cigarette butts or borrow from other residents. C2's medical record was reviewed. C2 was admitted with diagnoses that included chronic obstructive pulmonary diseas and nicotine dependence. A Resident Smoking Assessment dated 3/1/16 indicated C1 was safe to smoke unsupervised, however the question as to whether the resident agreed to follow smoking rules was left unanswered. A VA Assessment indicated smoking was a vulnerability and the intervention was the client was educated to take off her oxygen when smoking and the client would follow the licensee's strict smoking policy, although a smoking policy was not developed. The VA Assessment also failed to indicate oxygen use as a vulnerability. C2 was interviewed on 11/2/16 at 11:00 a.m. C2 stated until C1's incident she had brought her oxygen tank outside while smoking. C2 explained the "no oxygen use" signs were hung up the previous day. During an interview with ULP-C on 11/2/16 at 11:30 a.m., ULP-C stated C2 had always smoked outside with her oxygen tank prior to C1's incident. ULP-C explained C2 always turned off the tank herself prior to smoking, but still left it attached to her wheelchair. ULP-C stated that now the licensee is not allowing any oxygen tanks outside anymore.	0 810		

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0 810	Continued From page 11 During an interview with ULP-D on 11/2/16 at 1:25 p.m., ULP-D stated C2 went outside all the time with her oxygen tank. ULP-D stated sometimes C2 would turn off the tank on her own, other times C2 would just pull the nasal cannula down around her neck and kept the tank on. ULP-D added, staff told her she should not be smoking with her oxygen, but C2 refused removing the oxygen tank and stated she was fine. On 11/2/16 at 1:40 p.m. ULP-F also stated she had seen C2 smoke outside with her oxygen tank on multiple occasions. During an interview with LPN-B on 11/2/16 at 2:00 p.m., LPN-B stated C2 would go outside with her oxygen tank, turn it off and smoke. LPN-B stated when C2 was told not smoke with her oxygen tank, C2 would be non-compliant. Also, LPN-B explained the patio was not the designated smoking area, however the clients who smoked always went there. Therefore, LPN-B stated the licensee put a tent outside for the clients to use in the winter. LPN-B stated she did not know who would enforce the policies or rules if clients are non-compliant. C4's medical record was reviewed. C4 was admitted with diagnoses that included COPD, traumatic brain injury, and seizures. A VA assessment dated 5/16/16 failed to include the client's chronic conditions of COPD or seizures as a vulnerability, as well as C4's traumatic brain injury contributing to forgetfulness. In addition, smoking was not identified as a vulnerability. C4 was unable to vocalize clearly at all times to report any concerns. C4 was interviewed on 11/2/16 at 2:50 p.m. C4	0 810		

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0 810	Continued From page 12 was difficult to hear, with a quiet voice and difficulty with word finding. C4 did state C1 and C2 smoked outside with their oxygen tanks, but often pulled the oxygen tubing down from under their nose while they smoked. During an interview with registered nurse (RN)-A on 11/2/16 at 2:20 p.m., RN-A stated she was aware the assessments were lacking in information and was hired to improve the assessments on 10/3/16. The licensee policy titled "Maltreatment-Communication, Prevention and Reporting" dated 5-1-15 indicated each client receiving services shall have an individual abuse prevention plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
0 860 SS=H	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14	0 860		

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0 860	Continued From page 13 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to complete a fourteen day registered nurse (RN) assessment and a significant change assessment for two of four clients (C1, C4) reviewed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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: C1's medical record was reviewed. C1 began receiving services on 4/7/16 and was admitted with diagnoses that included chronic obstructive pulmonary disease, schizophrenia, bi-polar and diabetes. C1's service plan dated 9/7/16 indicated C1 required assistance with oxygen, dressing/grooming, showering,	0 860		

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0 860	Continued From page 14 transferring/mobility/escorts as needed, and medication assist. C1's last ninety day assessment was completed on 7/7/16. There were no other assessments in C1's record, including after a 9/12/16 and 10/3/16 hospitalizations. C1's nurse notes indicated C1 was hospitalized for shortness of breath on 9/12/16 to 9/15/16. On 10/3/16, C1 had a mood change from baseline, and oximeter readings of 62 percent to 79 percent. C1 refused nebulizer treatments and continued to take his oxygen off in order to smoke outside. C1 did agree to be seen in the emergency department and was hospitalized in the intensive care unit. C1 left against medical advice. The hospital had no new medication orders at discharge, but indicated C1 should stop smoking. C1 was seen by the physician assistant on 10/12/16, who recommended the following referrals: sleep study for BiPAP (Bilevel Positive Airway Pressure) use and an appointment with C1's primary physician for a medication review. C1 also requested from staff to start nicotine patches, and a physician order dated 10/12/16 was received to start Nicoderm. C1 requested to delay the start of Nicoderm until 11/1/16 and a physician order dated 10/13/16 indicated that was approved. C1 was seen by his physician on 10/18/16 who recommended C1 to maintain oxygen saturation between 85 and 90 percent and follow up with psychiatry as soon as possible. A psychiatry appointment was made for 11/11/16. C4's medical record was reviewed. C4 was admitted on 5/16/16 with diagnoses that included COPD, traumatic brain injury, and seizures. A RN admission assessment was completed on 5/16/16, however a fourteen day reassessment due 5/30/16 was not found in C4's record.	0 860		

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0 860	Continued From page 15 During an interview with RN-A on 11/2/16 at 2:20 p.m., RN-A stated she was aware the assessments were lacking in information and was hired to improve the assessments on 10/3/16. During an interview on 11/7/16 at 4:00 p.m., Owner-I stated the licensee previously had RN's with poor performance in place. Owner-I stated in spring 2016, two RN's who were terminated stole some client assessments from their records. Owner-I explained the licensee had been in the process of rebuilding a strong, reliable management team, including hiring RN-A and licensed practical nurse (LPN)-B on 10/3/16. The licensee policy titled "Assessment-Schedules" dated 5/1/15 indicated a reassessment will be completed by the RN within fourteen days after initiation of home care services. A change in client condition assessment will be completed by the RN as indicated. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 860		
01030 SS=I	144A.4793, Subd. 2 Policies and Procedures Subd. 2. Policies and procedures. (a) A comprehensive home care provider who provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.	01030		

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01030	Continued From page 16 (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting of treatment or therapy activities, educating and communicating with clients about treatments or therapy they are receiving, monitoring and evaluating the treatment and therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain a smoking policy, but required smoking clients to abide by a strict smoking policy for four of four clients (C1, C2, C3, C4) reviewed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1's medical record was reviewed. C1 began receiving services on 4/7/16 and was admitted with diagnoses that included chronic obstructive pulmonary disease, schizophrenia, bi-polar and diabetes. C1's service plan dated 9/7/16 indicated C1 required assistance with oxygen. An oxygen delivery slip indicated oxygen was delivered on 4/6/16 with the prescription of four liters per minute (LPM) of continuous oxygen. A pre-screening assessment dated 4/6/16 indicated	01030		

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01030	Continued From page 17 C1 smoked. A Resident Smoking Assessment dated 4/7/16 indicated C1 was safe to smoke outside unsupervised, however "no" was indicated for any additional concerns and oxygen use was not mentioned on the assessment. Also, no response was marked on the assessment for the question regarding whether the resident agreed to follow the smoking rules and smoke in designated areas. C2's medical record was reviewed. C2 was admitted with diagnoses that included COPD and nicotine dependence. A Resident Smoking Assessment dated 3/1/16 indicated C2 was safe to smoke unsupervised, however no response was marked on the assessment for the question regarding whether the resident agreed to follow the smoking rules and smoke in designated areas. C3's medical record was reviewed. C3 was admitted with diagnoses that included multiple sclerosis. C3's Resident Smoking Assessment dated 4/4/16 indicated C3 was safe to smoke unsupervised and indicated "yes" C3 had agreed to follow smoking rules and smoke in designated areas. C4's medical record was reviewed. C4 was admitted with diagnoses that included COPD, traumatic brain injury, and seizures. C4's Resident Smoking Assessment dated 5/16/16 indicated C4 was safe to smoke unsupervised and indicated "yes" C4 had agreed to follow smoking rules and smoke in designated areas. During an interview on 11/7/16 at 4:00 p.m., Owner-I stated there was no smoking policy and smoking was addressed in handbook. Owner-I stated she would develop a smoking policy that	01030		

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01030	Continued From page 18 included designated smoking areas and safety concerns. No smoking policy was completed. The licensee Resident Handbook indicated no smoking inside the building, but failed to indicate designated smoking areas or other rules. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01030		
02015 SS=G	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	02015		

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02015	Continued From page 19 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 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 licensee failed to report a maltreatment incident when a client was lit on fire while smoking with an oxygen tank for one of four clients (C1) reviewed.	02015		

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02015	Continued From page 20 This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: C1's medical record was reviewed. C1 began receiving services on 4/7/16 and was admitted with diagnoses that included chronic obstructive pulmonary disease, schizophrenia, bi-polar and diabetes. C1's service plan dated 9/7/16 indicated C1 required assistance with oxygen. An oxygen delivery slip indicated oxygen was delivered on 4/6/16 with the prescription of four liters per minute (LPM) of continuous oxygen. A pre-screening assessment dated 4/6/16 indicated C1 smoked. A Resident Smoking Assessment dated 4/7/16 indicated C1 was safe to smoke outside unsupervised, however "no" was indicated for any additional concerns and oxygen use was not mentioned on the assessment. Also, no response was marked on the assessment for the question regarding whether the resident agreed to follow the smoking rules and smoke in designated areas. An undated Vulnerable Adult Assessment indicated C1 was not vulnerable with unsafe smoking and oxygen use and mentioned C1 left his oxygen tank inside. C1's nurse notes indicated C1 was hospitalized for shortness of breath on 9/12/16 to 9/15/16. On 10/3/16, C1 had a mood change from baseline, and oximeter readings of 62 percent to 79 percent. C1 refused nebulizer treatments and continued to take his oxygen off in order to	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23743	A. BUILDING: _____ B. WING _____	C 11/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF MILACA	115 9TH ST NW SUITE 120 MILACA, MN 56353

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02015	Continued From page 21 smoke outside. C1 did agree to be seen in the emergency department and was hospitalized in the intensive care unit. C1 left against medical advice. The hospital had no new medication orders at discharge, but indicated C1 should stop smoking. C1 was seen by the physician assistant on 10/12/16, who recommended the following referrals: sleep study for BiPAP (Bilevel Positive Airway Pressure) use and an appointment with C1's primary physician for a medication review. C1 also requested from staff to start nicotine patches, and a physician order dated 10/12/16 was received to start Nicoderm. C1 requested to delay the start of Nicoderm until 11/1/16 and a physician order dated 10/13/16 indicated that was approved. C1 was seen by his physician on 10/18/16 who recommended C1 to maintain oxygen saturation between 85 and 90 percent and follow up with psychiatry as soon as possible. A psychiatry appointment was made for 11/11/16. An incident report dated 10/27/16 indicated staff escorted C1, with his oxygen tank in use, onto the patio outside of the dining room. Another client came into the dining room and alerted the licensed practical nurse (LPN) of an incident in which C1's oxygen tank was on fire. C1's nurse note dated 10/27/16 gave further detail that C1 was alert and stated "I forgot to take my oxygen off." There were noted facial burns and singed hair when the registered nurse (RN) assessed him, and C1 had already been escorted into the dining room. The RN extinguished the oxygen tank with law enforcement, and emergency services arrived to transport C1 to the hospital. A hospital report dated 10/27/16 to 11/11/26 indicated C1 was transported to a secondary hospital and admitted to the burn unit. C1 was intubated en route to the hospital and	02015		

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02015	Continued From page 22 experienced partial thickness (second degree) burns to the right side of the face (ear, eye, nose, and cheek). In addition, C1 also experienced soot staining in the trachea and mid thermal injury to the airway from smoke inhalation. Due to airway injury, C1 required tube feedings for nine days, after which he was increased to a soft diet with thickened liquids per evaluation from speech therapy. C1 was discharged back to the licensee on 11/11/16 with previous respiratory status, requiring four LPM of continuous oxygen via nasal cannula. However, C1 continued to require physical therapy, occupational therapy, speech therapy and a psychiatric consult to readjust medications. An on-site investigation was conducted on 11/1/16 and 11/2/16. On 11/1/16 past vulnerable adult reports submitted by the licensee were reviewed. There was no record of any licensee self-report for the incident involving C1 on 10/27/16. During an interview on 11/2/16 at 2:20 p.m., when RN-A was asked why the licensee had not submitted a VA report, RN-A stated licensed practical nurse (LPN)-B had submitted one, but RN-A was not sure when. During an interview on 11/2/16 at 3:00 p.m., LPN-B stated she did submit a telephone report and stated she had thought she had done it yesterday. The Office of Health Facility Complaints received a licensee self-report on 11/2/16. The licensee policy titled "Maltreatment-Communication, Prevention and Reporting" dated 5/1/15 did not included steps to	02015		

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02015	Continued From page 23 take when suspected maltreatment occurs nor the requirement to report suspected maltreatment immediately within twenty-four hours to the Minnesota Adult Abuse Reporting Center. TIME PERIOD FOR CORRECTION: Twenty One (21) days	02015		