

Office of Health Facility Complaints

Investigative Public Report

Maltreatment Report #: HL28686004M
Compliance #: HL28686005C

Date Concluded: October 20, 2021

Name, Address, and County of Licensee

Investigated:

Hyatt House
231 Washington Avenue
PO Box 10
Holdingford, MN 56340
Stearns County

Facility Type: Assisted Living

Investigator's Name: Jeri Gilb, RN, MSN, CNP
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):

It is alleged: The facility neglected the resident (R1) when they failed to implement increased monitoring and safety measures to keep R1 safe, resulting in self-injury and alcohol abuse.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility is responsible for the maltreatment. The facility was aware the resident had self-injurious behavior and failed to assess and implement safety measures to ensure the residents safety. The resident cut her wrist on 2 separate occasions with sharp objects she had in her possession.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The facility policies and procedures, resident medical record, staff training records, and residents hospital record were reviewed. Observations were made of the facility environment and staff and resident interaction. The investigator contacted law enforcement.

R1's diagnoses included chronic obstructive pulmonary disease (COPD), alcohol dependence, anxiety, depression, and suicidal behavior with attempted self-injury. R1 required staff assistance with meal preparation, medication management, safety checks, housekeeping, and laundry services. The service plan indicated R1 was at a high risk for falls and staff were directed to monitor R1's alcohol use.

On entrance to the facility in the early morning hours, investigators walked into the unlocked, propped open front doors. The two facility night staff were in the chairs at the front desk sleeping and needed to be awakened by the investigators. The facility kitchen door was unlocked and open wide with sharp knives in plain view and accessible laying in three separate bins on the kitchen counter.

The residents' medical records indicated R1 was evaluated or admitted to the hospital four different times in 25 days for self-injury, requiring stitches, suicidal ideation, and/or alcohol abuse. Each time the hospital discharged R1 back to the facility because they could not secure inpatient treatment for R1.

When interviewed, unlicensed facility staff stated they check on the resident if she uses her call light during the night. The staff stated there had been no changes to R1's plan of care since both of her self-inflicted injuries when she cut her wrists/ forearms. Staff were supposed to lock up sharp objects in her room, however, the resident comes and goes from the facility, so staff don't have control over what the resident "sneaks" back into the facility. Staff also stated the kitchen should be locked so the resident didn't have access to the knives. Staff stated there were no directions or schedule on how often to monitor R1 for self-abuse or alcohol use, and staff were unable to verbalize how frequently or what they should do to check on R1.

When interviewed facility management staff stated the facility does not have the capacity to safely care for the resident due to increased alcohol use and self-injurious behavior. Staff stated R1 is a danger to herself. Staff stated they have been unable to remove all sharp objects from R1's room because she leaves the facility frequently and continues to bring other sharp objects and alcohol into the facility. There were no clear guidelines for unlicensed staff to determine R1's intoxication level or when to hold medications that can be dangerous to administer when R1 uses alcohol.

Review of facility policies indicated staff are to be awake while working and the individual abuse plan should outline specific measures to minimize the risk of abuse to self and others.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

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

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

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

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

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: No.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Increase safety checks when intoxicated, search resident for sharp objects when returning from outing.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:

The Office of Ombudsman for Long-Term Care
County Attorney for Stearns County
Stearns County Law Enforcement

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2021
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NAME OF PROVIDER OR SUPPLIER HYATT HOUSE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340
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0 000	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: #HL28686004M/ #HL28686005C</p> <p>On, October 7, 2021, evaluators of this Department's staff, visited the above provider and the following correction order was issued. At the time of the evaluation, there was 10 clients that were receiving services under the assisted living care license.</p> <p>The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the evaluation. The following immediate correction order is issued for #HL28686005C/#HL28686004M, tag identification 630.</p> <p>On October 12, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL28686005C/#HL28686004M. At the time of</p>	0 000	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are 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.</p> <p>Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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0 000	Continued From page 1 the evaluation, there were 10 residents receiving services under the assisted living license. The immediacy for tag 630 was removed. However, non-compliance remains at a scope and level of D. In addition, the following correction orders are issued, tag 470 and tag 2360.	0 000		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	<p>Continued From page 2</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure night staff were awake to monitor resident 1 (R1) needs and to minimize the risk of self-abuse. This had the potential to affect all 10 residents residing in the facility.</p> <p>This practice resulted in a level three violation (a violation that harmed a residents 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 residents).</p> <p>Findings include:</p> <p>During an observation on October 7, 2021, at 5:00 a.m., investigators walked into the facility. The front doors to the facility were propped open. Two facility night staff were at the desk. Unlicensed personal (ULP)-D was laying on two chairs pushed together with his eyes closed sleeping. ULP-C was sitting in a chair with her head down and covered with the hood of her sweatshirt sleeping. The investigators called out to staff multiple times and ULP-C woke up and told ULP-D to, "Get up."</p> <p>R1's Individual Abuse Prevention Plan dated September 13, 2021, indicated R1 agreed to have staff lock sharp objects in a safe to prevent her from harming herself.</p> <p>R1's Assessment dated October 4, 2021,</p>	0 470		
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0 470	<p>Continued From page 3</p> <p>indicated R1 had a history of self-injury, cutting, and a history of suicidal ideation. R1 had 7 sutures in place during the assessment from cutting herself on her forearm/wrist on September 30, 2021.</p> <p>When interviewed on October 7, 2021 at 5:45 a.m., ULP-C stated they are not supposed to be sleeping but it was hard to stay awake all night. She stated she had been sleeping for approximately 1/2 hour. ULP-C stated staff "usually" kept the kitchen locked because R1 is not safe to have sharp objects; however, the kitchen was currently unlocked because staff had been in the kitchen earlier in the night.</p> <p>During interview on October 7, 2021, at 11:01 p.m., registered nurse (RN)-B stated night staff are expected to be awake, and they should not have been sleeping.</p> <p>The facility policy titled Staffing and Direct Care Plan Policy dated August 1, 2021, indicated staff are to be awake while working.</p> <p>TIME PERIOD OF CORRECTION: Two (2) days</p>	0 470		
0 630 SS=G	<p>144G.42 Subd. 6 Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person</p>	0 630		

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0 630	<p>Continued From page 4</p> <p>and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a safety plan with specific interventions for each known vulnerability for one of one resident (R1) reviewed for safety. This resulted in harm when R1 had ongoing access to sharp objects, cut her wrist, and was transported to the hospital for care.</p> <p>This was issued at an immediate level related to the lack of safety interventions to ensure the residents ongoing safety.</p> <p>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).</p> <p>The findings include:</p> <p>R1's service plan dated, August 25, 2021, indicated the resident was admitted to the facility on August 20, 2021, with diagnoses including chronic obstructive pulmonary disease (COPD), alcohol dependence, anxiety, depression, and suicidal behavior with attempted self-injury. The resident required staff assistance with meal preparation, medication management, safety checks, housekeeping, and laundry services.</p>	0 630		

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0 630	<p>Continued From page 5</p> <p>R1's service plan also indicated R1 was at a high risk for falls and staff were directed to monitor the residents alcohol use.</p> <p>R1's Individual Abuse Prevention Plan dated September 13, 2021, indicated R1 agreed to have staff lock sharp objects in a safe to prevent her from harming herself.</p> <p>R1's Assessment dated October 4, 2021, indicated R1 was a chronic alcoholic and was binge drinking. The assessment indicated R1 had a history of self-injury, cutting, and a history of suicidal ideation. Although R1 denied thoughts of suicide the day the assessment was completed, R1 had 7 sutures in place during the assessment from cutting herself on her forearm/wrist on September 30, 2021.</p> <p>R1's undated Safety Plan indicated R1 could contact staff, the Crisis Response Team, and/or the Ombudsman when R1 felt she needed help, was feeling down, or felt like cutting herself. In addition, staff were directed to ensure R1's environment was safe by locking up sharp objects in R1's safe.</p> <p>A facility incident report regarding R1 dated September 10, 2021, indicated the facility staff contacted 911 when R1 cut her wrist. R1 was transferred by ambulance to the hospital and received treatment on her left wrist/ forearm for a self inflicted cut with a knife. The incident report indicated the facility interventions to prevent further self-harm included "documentation in the resident services note, physician evaluation, service plan revised, abuse assessment and prevention plan updated."</p> <p>A facility incident report dated September 30,</p>	0 630		

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0 630	<p>Continued From page 6</p> <p>2021, indicated R1 cut her left wrist, staff called 911, and R1 was transported by ambulance to the hospital and received treatment for a self inflicted cut. The facility interventions identified to prevent further self-harm indicated "general" on the facility Incident Report.</p> <p>R1's hospital records indicated on October 3, 2021, R1 presented to emergency department for alcohol intoxication. R1 left the facility and went to a motel in a town approximately 20 miles away from the facility. The motel staff contacted emergency medical support due to R1's extreme intoxication. R1 fell and hit her head while intoxicated, but there were no acute abnormalities on diagnostics. R1 told the medical provider she would like to go to a detox center, but R1 was not accepted into the program. R1 was discharged from the emergency department and sent by cab back to the facility.</p> <p>R1's hospital records indicated on October 4, 2021, R1 was [again] in the nearby town approximately 20 miles from the facility and was found in the street intoxicated. R1 refused to cooperate with law enforcement and was transported to the hospital. The hospital notes indicated R1 was discharged from the hospital the previous day and took a cab back to town shortly after returning to her facility after previous discharge. The hospital course of care indicated the resident had behavioral issues with diagnoses of alcohol abuse. R1 declined any further treatment and was discharged from the hospital back to the facility.</p> <p>Review of R1's progress notes for the previous 6 months indicated 32 documented instances of intoxication, drinking in her room, or trips to the local bar.</p>	0 630		

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0 630	<p>Continued From page 7</p> <p>R1's progress notes dated April 14, 2021, at 6:46 a.m., indicated R1 was in the kitchen playing with knives and held a knife to her wrist.</p> <p>R1's progress notes dated May 7, 2021, at 7:06 p.m. indicated R1 had a cut on her hand, but denied it was purposeful.</p> <p>R1's progress notes dated May 15, 2021, indicated R1 told staff she "hates life".</p> <p>R1's progress notes dated May 18, 2021, indicated staff removed 12 full bottles of vodka from R1's room.</p> <p>R1's progress notes dated June 3, 2021, indicated R1 had a bandage on her wrist and reported she cut it accidentally while trying to remove a bracelet.</p> <p>R1's progress notes dated July 29, 2021, at 9:10 p.m. indicated R1 fell while intoxicated.</p> <p>R1's progress notes dated July 31, 2021, indicated R1's safety checks were increased due to falls while intoxicated and the nurse advised staff to push fluids.</p> <p>R1's progress notes dated July 31, 2021, indicated R1 stated to staff she "doesn't have a life and doesn't want to do it anymore".</p> <p>R1's progress notes dated August 16, 2021, indicated R1 stated she would like help to quit drinking.</p> <p>R1's progress notes dated August 17, 2021, indicated R1 went to the hospital due to chest pain.</p> <p>R1's progress notes dated August 22, 2021, indicated R1 returned to facility from hospitalization with diagnoses of alcohol induced gastritis.</p> <p>R1's progress notes dated August 23, 2021, indicated the resident's case manager requested staff complete a "Vulnerable Adult" report every time R1 was drinking or intoxicated.</p> <p>R1's progress notes dated September 1, 2021, indicated R1 told staff she wanted to go to a</p>	0 630		

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0 630	<p>Continued From page 8</p> <p>detox center because of withdrawal symptoms, however, the detox center refused to admit R1 because of her oxygen use.</p> <p>R1's progress notes dated September 13, 2021, indicated R1 refused inpatient alcohol treatment but would consider outpatient treatment. R1 also refused psychiatry but stated she would consider psychotherapy. Staff requesting companion care for R1. The progress note indicated the facility staff removed as many sharp objects as they could locate in R1's room and placed them in a safe.</p> <p>R1's progress notes dated October 2, 2021, indicated R1 left the facility by cab and did not return back to the facility that night.</p> <p>R1's progress notes dated October 3, 2021, indicated staff received a call from R1, and she was very intoxicated and angry because staff would not leave facility and pick her up. The hospital called and facility staff were unaware R1 was at the hospital. A hospital nurse informed the facility staff that R1 was found very intoxicated at a motel and was transported to the hospital by ambulance. The note indicated R1 returned to the facility from the hospital but within 45 minutes left by cab to go back to the motel.</p> <p>R1's progress notes dated October 4, 2021, indicated R1 never returned to the facility from the previous night. Staff then received a call from the hospital stating law enforcement brought R1 to the hospital after finding her intoxicated in the roadway. The hospital discharged R1 to the facility because the detox center would not admit her.</p> <p>R1's medication administration records (MAR) from July 2021 until October 2021 direct staff to hold R1's Trazodone if R1 is intoxicated.</p> <p>During observation on October 7, 2021, at 5:00</p>	0 630		

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0 630	<p>Continued From page 9</p> <p>a.m., investigators entered the facility and walked into the unlocked, propped open front doors. The two facility night staff were in the chairs at the front desk sleeping and needed to be awakened by the investigators. The facility kitchen door was unlocked and open wide with sharp knives in plain view and accessible laying in three separate bins on the kitchen counter.</p> <p>During interview on October 7, 2021, at 5:45 a.m. unlicensed personnel (ULP)-C stated on the overnight shift they check on R1 if she uses her call light to request assistance, however, staff do not have specific times or frequency they are directed to check on R1. ULP-C stated staff "usually" keep the kitchen locked because R1 is not safe to have sharp objects; however, the kitchen was currently unlocked because staff had been in the kitchen earlier in the night.</p> <p>During interview on October 7, 2021, at 10:13 a.m., ULP-A stated she was present both times R1 cut herself. The first time, R1 used a knife she kept in her room. The second time R1 cut herself, she used a razor blade from an Exacto knife she had in her room. ULP-A stated R1 had a lot of craft supplies, and staff found a box of razor blades while R1 was in the hospital. ULP-A stated staff made "no real changes" regarding the care and/or supervision for R1 since admission except locking up sharp objects from her room in the safe. ULP-A stated staff were directed to check on R1 2-3 times a day. However, ULP-A stated if she noticed R1 was drinking, she checked on R1 2-3 times on her shift. ULP-A stated there was no clear schedule for checking on R1 and most staff only check R1's room for alcohol if R1 is intoxicated. ULP-A has never checked R1's room for sharp objects or alcohol. ULP-A stated R1 leaves the facility frequently and</p>	0 630		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2021
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NAME OF PROVIDER OR SUPPLIER HYATT HOUSE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340
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(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
0 630	<p>Continued From page 10</p> <p>if R1 returns intoxicated, staff check on her "a little more." ULP-A was unable to verbalize a schedule of how frequently or what kind of check is completed.</p> <p>During interview on October 7, 2021, at 11:01 a.m., facility registered nurse (RN)-B stated the facility does not have the capacity to safely care for R1 due to her increased alcohol use and self-injurious behavior. RN-B stated she asked the hospital for assistance and admission to a psychiatric facility or treatment center to help R1 because she is a danger to herself. RN-B completed a safety plan for R1 with the help of the Ombudsman, however, RN-B indicated the safety plan does not contain specific individualized interventions to ensure R1's safety. RN-B stated staff have not been able to remove all of the sharp items from R1 as R1 leaves the facility frequently and continues to bring other sharp objects into the facility. RN-B stated there is no way to prevent R1 from drinking when she is away from the facility. If R1 is intoxicated staff are directed to hold R1's Trazodone, however, there are no clear guidelines for ULPs to determine intoxication level or when to specifically hold the medication. RN-B stated staff are doing organization daily with R1 to help her clean her room and they are trying to look for items of danger at that time. RN-B stated this direction is not documented for staff, however, it was communicated with staff.</p> <p>The facility policy titled, Staffing and Direct Care Plan Policy, dated August 1, 2021, indicated staff are to be awake while working.</p> <p>The facility policy titled, Vulnerable Adult Maltreatment Policy, dated August 1, 2021, indicated the individual abuse prevention plan will</p>	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2021
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0 630	Continued From page 11 include specific measures to minimize the risk of abuse to others and self-abuse. TIME PERIOD TO CORRECT-Two (2) days	0 630		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On October 7, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	