

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL354735001M Date Concluded: January 6, 2021

Compliance #: HL35475002C

Name, Address, and County of Licensee

Investigated:

Hazel Senior Living LLC 1109 Hazel St North St Paul, MN 55119 Ramsey County

Facility Type: Home Care Provider Investigator's Name: Carol Moroney, RN,

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 client when the client wandered out of the facility. The client was unable to re-enter the building and died of hypothermia.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility was responsible for the maltreatment. The client had a history of wandering and the staff failed to ensure the client was monitored for safety. The client left the facility through an unlocked, unalarmed door when the staff were not aware. The door locked from the outside and the client was unable to re-enter the facility. The client was found outside approximately seven hours later since staff last saw the client. The client died of hypothermia.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The police report, autopsy results, client medical records, and the

facility video were reviewed. The staff schedule, related policies, and applicable employee training/competencies were requested for review but not provided.

The client had diagnoses including dementia and a history of strokes. The client had a history of wandering in and outside of the facility and was assessed as being at risk for elopement. Due to the clients wandering, staff were directed to complete safety checks on the client every hour. The facility investigation indicated the operations manager got a call early one morning from staff asking if the client was in the hospital. The client's bed was still made, and staff could not locate him. The operations manager told staff to look for the client. Approximately 1 ½ hours later the operations manager arrived at the facility and saw the client laying outside the facility on the ground. Staff carried the client into the facility and described the client as being "rigid." When staff brought C1 into the facility his clothes were wet, and they covered him with a blanket. Staff called the facility registered nurse and were directed to obtain vital signs and call 911. When paramedics arrived, they stated C1 was deceased. C1 was on hourly safety checks, however, the evening/overnight staff were asleep and indicated they did not complete the hourly checks on the client. The investigation indicated the facility security footage showed C1's pants were soaked prior to exiting the facility. The security footage indicated the client exited the facility front door approximately 7 hours prior to staff finding him outside. The door was unlocked and unalarmed, so the client was able to exit without staff knowledge. However, the door locked from the outside and a key or security badge was required to enter back into the facility.

When interviewed staff stated the client had a difficult time sleeping and often wandered around the facility. The staff working the night the client wandered out of the facility stated the client was wandering around the facility and he was difficult to re-direct. Eventually, she was able to get the client to go to his room and he shut the door. The staff stated she had worked a double shift (from 2:00 p.m. until 7:00 a.m.) and was told she could sleep during the night. The staff member reported she went to sleep between 2:00 a.m. – 3:00 a.m. The staff left the facility at approximately 6:20 a.m. and had not completed any checks on the client after she assisted him to his room earlier that night.

The operations manager stated she was called by the dayshift staff stating they couldn't locate the client. Staff were directed to look for the client and she would come to the facility. The operations manager arrived at the facility approximately 1½ hours later and saw the client laying outside in the dirt with his head on a sandbag. She stated staff carried the client in, called the facility nurse, and contacted 911.

When interviewed the medical examiner indicated when he arrived at the facility the client had been moved into the facility and a heater was set up blowing on him. The client had a scrape on his extremities and on his left ear. There was a small amount of blood on the front steps of the facility. The client slippers were off and were located outside near the site the client was found. The medical examiner stated it was difficult to determine C1's time of death due to the heater blowing on the client.

When interviewed the client's family member stated they received a call from the facility informing them the client passed away. The family member stated they were told the client was observed on camera getting a glass of water at approximately 2:30 a.m. and then was not seen on camera again. The staff person on duty was sleeping and did not check on the client every hour. The family member stated the police officer told her there was a small amount of blood on the facility steps, but the client was found lying in a dirt pile near the facility. The family member stated the client should have been checked on every hour because he attempted to get out of the facility several times prior to this incident.

The clients autopsy report indicated no injury prior to death, abrasions on the left and right toes, and no injuries of internal traumatic injuries were found. The cause of death was hypothermia due to cold exposure.

In conclusion neglect was substantiated. The facility failed to ensure the front door had a lock and an alarm. The facility failed to ensure the staff monitored C1 every hour as directed due to his history of wandering.

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.

Insert maltreatment definition here.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

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

Vulnerable Adult interviewed: No, deceased Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility: Put a lock and an alarm on the front door.

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 Ramsey County Attorney St Paul City Attorney St Paul Police department

Minnesota Department of Health

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		H35475	B. WING		01/0	4/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HAZEL S	ENIOR LIVING LLC	1109 HAZ	EL STREET	NORTH		
		SAINT PA	UL, MN 551	l19		
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	******ATTENTION** HOME CARE PROCORRECTION OR In accordance with 144A.43 to 144A.48 of Health issued a ca survey. Determination of wherequires compliance provided at the state When a Minnesota items, failure to combe considered lack INITIAL COMMENT On December 3, 20 Department of Health complaint #HL3547 the time of the survey receiving services of license. The following is issued. Correction correct that are not later date during the The following immediate of the survey and the survey of the survey	Minnesota Statutes, section 32, the Minnesota Department correction order(s) pursuant to mether a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance. TS: 20, the Minnesota alth initiated an investigation of 5002C/#HL35475001M. At ey, there were #8 clients ander the comprehensive and immediate correction order in orders with a period to immediate may be issued at a expression.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far left column entit Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficienc column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Cor PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TFEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SITURDING STATUTES.	oftware. to e Care ber led "ID ber and Statute ies" s the e state This as eyors' rection. ONG OF	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

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0 265	receives home care in an assisted living chapter 144G has to (2) receive care an suitable and up-to-caccepted health care standards and personactive part in development in	ment of rights. (a) A client who services in the community or facility licensed under hese rights: d services according to a late plan, and subject to re, medical or nursing on-centered care, to take an oping, modifying, and	0 265	DEFICIENCY)		
	Findings include:	to develop and implement				
	consistent intervent	ions to prevent client #1 from cility's unlocked, unalarmed				

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front door. The client was assessed to require every two hours safety checks, the physician's order was for every hour safety checks, and when staff were interviewed they stated C1 should be checked on every hour. Although staff documented they completed C1's safety checks hourly on November 15, 2020, C1 was not seen by staff for approximately eight hours (midnight until 8:00 a.m.). The client was found outside the facility and died of hypothermia. This resulted in an immediate correction order. C1 was admitted to the facility on August 25, 2020. The client had diagnoses including dementia, and a history of stroke with left sided weakness. C1's nursing assessment dated August 25, 2020, indicated staff were to perform safety checks every two (2) hours. C1 was identified at risk for elopement, had a history of attempted elopements, and occasionally wandered into other clients rooms. Staff were instructed to redirect the client, perform safety checks, and ensure the client was safe. C1 had impaired judgement and difficulty communicating. C1's main language was Hmong. C1's signed physician orders dated August 25, 2020, directed staff to complete, "Safety Check 24 times per day, Daily." C1's service plan dated September 11, 2020, listed services including, monitor for elopement,	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
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0 265	C1's facility progress prior attempts to leafrom August 25, 202 and indicated: - August 26, 2020, outside without notice August 28, 2020, to leave the facility redirected the client room; - September 1, 202 attempted to go out alarm alerted staff; - September 11, 202 10, 2020, at 1:30 p. tried to leave the facility to leave t	lients assessed needs. Is notes regarding the clients ave the facility were reviewed 20, to November 15, 2020, indicated the client went fying staff and had a fall; indicated the client attempted through the side door. Staff and brought him back to his 20, indicated the client attempted the side door and the door 20, indicated on September m. and at 3:30 p.m. the client cility through the side door; 20, indicated the client tried through the side door; and 0, indicated the client got	0 265			
	completed by the operations approximately 8:00 and if he was in the manager told ULP-I the hospital and state approximately 9:30 called regarding C1 operations manage C1 laying outside of Another staff members and C1 was described. The Executive directions of the executive directions manage C1 was described.	on dated November 15, 2020, perations manager indicated lel (ULP)-F called her at a.m., to ask where C1 was hospital. The operations F she did not think C1 was in aff should look for the client. hager arrived at the facility at a.m., 1 1/2 hours after staff 's whereabouts. When the r arrived at the facility she saw if the facility on the ground. Ser carried C1 into the facility				

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0 265	outside the facility in staff believed he may staff brought C1 into wet and he was concalled the facility redirected to obtain viparamedics arrived deceased. The day a.m. on November was in the hospital made and he wasn't hourly safety check overnight staff, unlicated as concalled the facility. Because showed C1's pants the facility. Because sleeping, she did not the facility, nor were for C1. The facility lacked of staff's search for C2. The "R-Task" document of the "R-Task" document of the sactivity to ensure the staff's activity to ensure the sactivity the sactivity to ensure the sactivity the sactiv	r stated when C1 was found he was cold to the touch and ay have been breathing. When to the facility his clothes were wered with a blanket. Staff gistered nurse and were stall signs and call 911. When they stated C1 was was staff member (started at 6:00 15, 2020) had assumed C1 because his bed was still it in his room. C1 was on so, however, the evening/censed personal (ULP)-F, was hight of November 15, 2020, asks were not completed. The sted the facility security footage were soaked prior to exiting the staff member was not see or hear the client leave any safety checks completed documentation of the facility or any actions taken on the facility of the staff member was not see or hear the client leave any safety checks completed documentation of the facility or any actions taken on the facility of the staff member was not see or hear the client leave any safety checks completed documentation of hourly checks for the his safety, dated the facility of the staff member was not see or hear the client leave any safety checks completed documentation of hourly checks for the his safety, dated the safety was documented by the		DEFICIENCY)		
	at 5:59 a.m., as "cli	ing was documented by ULP-F ent is in room";				

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2065 Continued From page 5 - 4.00 a.m., as "client is in room"; - 5.00 a.m. monitoring was documented by ULP-F at 6:00 a.m., as "client is in room"; - 6.00 a.m. monitoring was documented by ULP-F at 7:00 a.m. monitoring was documented by ULP-E at 7:02 a.m., as "client is in room"; - 7:00 a.m. monitoring was documented by ULP-E at 7:02 a.m., as "not home"; - 7:00 a.m. monitoring was not documented; - 9:00 a.m. monitoring was not documented; - 9:00 a.m. monitoring was not documented; - 10:00 a.m. monitoring was not documented by ULP-E at 12:47 p.m., as "not home"; - 11:00 a.m. monitoring was documented by ULP-E at 12:47 a.m., as "not home". Although ULP-F documented completing hourly safety checks on C1 overnight on November 15, 2020, the client was not observed during any of the documented checks. C1's autopsy report dated November 16, 2020, indicated cause of death "Hypothermia due to cold exposure" and "Abrasions of the left and right toes." During an interview on December 8, 2020 at approximately 2:00 p.m., C1's family member (FM)-G stated on November 15, 2020 at approximately 9:45 a.m., the facility called to inform her C1 passed away. The facility told FM-G the client wandered out of the facility and was found dead earlier that morning. FM-G was told according to the facility video footage, C1 got a glass of water at 2:30 a.m. and then was not seen any more on camera. The staff person on duty was sleeping. FM-G stated the police officer told her there was a small amount of blood on the facility steps, but the client was found lying in a dirt pile. FM-G stated C1' should have been on every hour checks because he attempted to get	- 4:00 a.m. mo at 6:00 a.m., as - 5:00 a.m. mo at 6:02 a.m., as - 6:00 a.m. mo ULP-E at 7:01 - 7:00 am. mor at 7:02 a.m., as - 8:00 am. mor - 9:00 a.m. mo - 10:00 a.m. mo ULP-E at 12:47 - 11:00 a.m. mo ULP-E at 12:47	nonitoring was documented by ULF as "client is in room"; nonitoring was documented by ULF as "client is in room"; nonitoring was documented by 1 a.m., as "not home"; nonitoring was documented by ULF as "not home"; nonitoring was not documented; nonitoring was not documented; monitoring was not documented; monitoring was documented by 47 p.m., as "not home"; and monitoring was documented by 47 a.m., as "not home". P-F documented completing hourly son C1 overnight on November 15 and was not observed during any of ted checks. Teport dated November 16, 2020, use of death "Hypothermia due to be" and "Abrasions of the left and "erview on December 8, 2020 at y 2:00 p.m., C1's family member d on November 15, 2020 at y 9:45 a.m., the facility called to 1 passed away. The facility told ent wandered out of the facility and ead earlier that morning. FM-G was g to the facility video footage, C1 geter at 2:30 a.m. and then was not re on camera. The staff person on eping. FM-G stated the police office was a small amount of blood on the but the client was found lying in a G stated C1 should have been on	no a no	by ULP-F by ULP-E by ULP-E ed; ted; ted; thourly ber 15, any of 2020, ue to and 0 at mber d to cold ity and -G was e, C1 got as not son on e officer od on the ng in a en on	0 265			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H35475	B. WING		01/0) 4/2021
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0 265	incident. FM-G state was unlocked from but the side door had but the side door had approximately 2:30 H stated when he at November 15, 2020 facility and a heater ME-H stated C1 had and on his left ear. blood on the front solippers were off and the site the client was difficult to determine heater blowing on the site the facility. The staff can approximately 3:45 (OM)- B stated on heater blowing on the saw C1 lying in her car. Another enfacility. The staff can urse and were directly thought C1 was tried to warm C1 upparamedics arrived deceased. OM-B solitity was only lock was no alarm on the exited the facility. Our instructed to check the day in the control of the control	veral times prior to this ed she was told the front door the inside and had no alarm, ad a lock and alarm on. on December 11, 2020, at p.m., medical examiner (ME)-rrived at the facility on 0, C1 had been moved into the was set up blowing on him. It is a scrape on his extremities. There was a small amount of teps of the facility. C1's id were located outside near as found. ME-H stated it was e C1's time of death due to the ne client. on December 14, 2020, at p.m., operations manager November 15, 2020, she y at approximately 9:30 a.m. in the dirt near where she parks imployee carried C1 into the alled the facility registered ected to call 911. OM-B stated is possibly still alive and they of OM-B stated when the they stated C1 was tated the front door of the ked from the outside and there is door to alert staff if someone of M-B stated staff were				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	
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HAZEL S	SENIOR LIVING LLC		EL STREET UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 265	elopement. RN-D swere to be complete the overnight hours RN-D stated the froinside or have an all the door did lock frowas not possible wishe had observed of facility through the fistated on November 3:00 a.m. ULP-Enfound and asked if told ULP-E, she was hospital and instruction. During an interview approximately 2:00 (ULP)-F stated she from November 14, November 15, 2020 late in the evening (became agitated and ULP-F attempted to be agitated and was language (Hmong). understand C1 (spellanguage) so she to and the registered response. Eventual go into his room an stated she was told since she was work fell asleep around 2 stated she woke up check on and/or ob	ecks to reduce the risk of stated C1's hourly checks ed and documented even in when the client was sleeping. In the door did not lock from the larm on it. RN- D confirmed om the outside, so re-entry thout a badge. RN-D stated C1 attempting to leave the front door in the past. RN-D et 15, 2020, at approximately otified her C1 could not be the went to the hospital. RN- D is not aware of C1 going to the ted staff to search for him. On December 15, 2020, at p.m., unlicensed personal was working a double shift from 2:00 p.m., until 0, 6:00 a.m. ULP - F stated funsure of the time) C1 and was trying to go upstairs. Or redirect C1. He continued to stalking in his homeland ULP-F was unable to eaking in his homeland exted the operations manager nurse but received no by ULP-F was able to get C1 to do the shut the door. ULP-F is she could sleep overnight around 5:00 a.m. and did not serve C1 prior to completing the facility at approximately of the facili				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE S	
	H35475	B. WING		01/0	; 4/2021
NAME OF PROVIDER OR SUPPLIER HAZEL SENIOR LIVING LLC	1109 HAZE	DRESS, CITY, S EL STREET I JL, MN 551'		•	
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
p.m., ULP-C stated or was found at approxing ground outside the factoried C1 inside the full of the ULP-C thought C1 has so they put him by a has context of the facility multiple time able to redirect him. It aware C1 was at risk hourly safety checks with client. During interview on Dea.m., executive directed November 15, 2020, at the operations manage was found outside and stated earlier that more locate C1 and his bed stated the front door consider and did not alar through the door. The the outside and an active enter. ED-A stated be checked on every leadering, and staff with gotten outside the factories in regarding safety checked on the facilities. The facilities policies is regarding safety checked on the facility. No further information	pecember 15, 2020, at 2:20 in November 15, 2020, C1 mately 9:30 a.m. lying on the cility. ULP-C stated when he facility, his body was rigid. In a pulse and respirations neater to warm him up. ULP mpted to wander away from the sin the past but staff were ULP-C stated staff were for elopement, which is why were completed on the secember 16, 2020, at 10:00 for (ED)-A stated on the staff were not approximately 9:30 a.m. ager called and told her C1 did he was really cold. ED-A ming staff were not able to did was still made. ED-A did not have a lock on the rm when someone exited the front door was locked from access card is needed to C1 had been assessed to hour because of his risk for were not aware he had cility on November 15, 2020. In place prior to the incident arequested but not provided	0 265			

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	
			7 t. DOILDING.			;
		H35475	B. WING			4/2021
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HAZEL S	ENIOR LIVING LLC		EL STREET UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 325	Continued From pa	ge 9	0 325			
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment	0 325			
	receives home care in an assisted living chapter 144G has the (14) be free from phase neglect, financial examples and the atment cover.	ment of rights. (a) A client who services in the community or facility licensed under hese rights: hysical and verbal abuse, eploitation, and all forms of ed under the Vulnerable Maltreatment of Minors Act;				
	by: Based on interview facility failed to ensure reviewed (C1) was eloped in inclement	ent is not met as evidenced ent is not met as evidenced es, and document review, the ure one of one clients free from maltreatment. C1 weather while dressed died from hypothermia.		No Plan of correction is required for please refer to the public maltreating report for details.	•	
	Findings include:					
	Department of Heal determination that refacility was response connection with incitacility. The MDH connection with the modern connection with the modern connection with the modern connection.	2020, the Minnesota Ith (MDH) issued a neglect occurred, and that the sible for the maltreatment, in idents which occurred at the oncluded there was a evidence that maltreatment				
	144A.4791, Subd. 9 Implementation & R	•	0 865			
	revisions to service	n, implementation, and plan. (a) No later than 14 that home care services are				

Minnesota Department of Health

STATE FORM U6HZ11 If continuation sheet 10 of 18

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H35475	B. WING		01/0) 4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAZEL S	ENIOR LIVING LLC		EL STREET UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	(b) The service plar include a signature home care provider client's representation the services to be must be revised, if review or reassesses. The provider must client about change services and how to Ombudsman for Loc (c) The home care provide all services service plan. (d) The service plar must be entered into notice of a change is applicable. (e) Staff providing hinformed of the curron the facility in indressed inappropriation to the service of the curron the facility in indressed inappropriation the facility in indressed inappropriation to the service of the curron the facility in indressed inappropriation the facility in indressed inappropriation.	me care provider shall finalize rvice plan. In and any revisions must or other authentication by the rand by the client or the redocumenting agreement be provided. The service plan needed, based on client ment under subdivisions 7 and st provide information to the rest to the provider's fee for contact the Office of the required by the current In and revised service plan or the client's record, including in a client's fees when In one care services must be rent written service plan. In and document review, the review services based on the reds identified in the nursing form of the clients (C1) reviewed. In and completed as assessed and harm when C1 eloped reclement weather while retely. C1died from	0 865			
	i nis practice resulte	ed in a level three violation (a				

Minnesota Department of Health

STATE FORM U6HZ11 If continuation sheet 11 of 18

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H35475	B. WING		01/0) 4/2021
	PROVIDER OR SUPPLIER	1109 HAZ	DRESS, CITY, S EL STREET UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	not including serious or a violation that has serious injury, impairs issued at an isolate limited number of collimited number of collimited number of sistuation has occurred. The climited number of sistuation has occurred. The client has admitted to 2020. The client has dementia, and a his weakness. C1's nursing assess indicated staff were every two (2) hours elopement, had a helopements, and occurred the client was judgement and difficulty and the client was judgement and difficulty three times daily; be aggression thre	d a client's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was discope (when one or a lients are affected or one or a lients are involved or the led only occasionally). The facility on August 25, and diagnoses including litory of stroke with left sided sment dated August 25, 2020, to perform safety checks. C1 was identified at risk for istory of attempted licasionally wandered into list of staff were instructed to lierform safety checks, and as safe. C1 had impaired culty communicating. C1's Hmong. The dated August 25, and light are instructed to lierform safety checks, and light are instructed to lierform safety checks. The dated August 25, to complete, "Safety Check"	0 865			

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STATE FORM U6HZ11 If continuation sheet 12 of 18

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED	
				С		
		H35475	B. WING		01/04/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAZEL S	SENIOR LIVING LLC		EL STREET UL, MN 551			
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 865	Continued From pa	ge 12	0 865			
	C1's facility progress notes regarding the clients prior attempts to leave the facility were reviewed from August 25, 2020, to November 15, 2020, and indicated: - August 26, 2020, indicated the client went outside without notifying staff and had a fall; - August 28, 2020, indicated the client attempted to leave the facility through the side door. Staff redirected the client and brought him back to his room; - September 1, 2020, indicated the client attempted to go out the side door and the door alarm alerted staff; - September 11, 2020, indicated on September 10, 2020, at 1:30 p.m. and at 3:30 p.m. the client tried to leave the facility through the side door; - September 14, 2020, indicated the client tried to leave the facility through the side door; - September 14, 2020, indicated the client got dressed and wanted to go outside. A facility investigation dated November 15, 2020, completed by the operations manager indicated unlicensed personnel (ULP)-F called her at approximately 8:00 a.m., to ask where C1 was and if he was in the hospital. The operations manager told ULP-F she didn't think C1 was in the hospital and staff should look for the client. The operations manager arrived at the facility at the					
	approximately 9:30 a.m., 1 1/2 hours after staff called regarding C1's whereabouts. When the operations manager arrived at the facility she saw C1 laying outside of the facility on the ground. Another staff member carried C1 into the facility and C1 was described as rigid.					
	The Executive director completed an investigation on November 15, 2020, which indicated the operations manager stated when C1 was found					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
H35475		B. WING		C 01/04/2021		
HAZEL SENIOR LIVING LLC			DRESS, CITY, S EL STREET I UL, MN 551'			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	E ACTION SHOULD BE COMPLED TO THE APPROPRIATE DATE	
0 865	staff believed he may staff brought C1 into wet and he was concalled the facility redirected to obtain viparamedics arrived deceased. The day a.m. on November was in the hospital made and he wasn' hourly safety check overnight staff, unlicated as a seep on the overnight staff, unlicated investigation indicated showed C1's pants the facility. Because sleeping, she did not the facility, nor were for C1. The facility lacked of staff's search for C2. The facility lacked of staff's search for C3. The "R-Task" docured to staff's search for C3.	the was cold to the touch and any have been breathing. When to the facility his clothes were wered with a blanket. Staff gistered nurse and were tal signs and call 911. When they stated C1 was weath staff member (started at 6:00 15, 2020) had assumed C1 because his bed was still to the in his room. C1 was on so, however, the evening/censed personal (ULP)-F, was hight of November 15, 2020, ks were not completed. The staff member was not see or hear the client leave the staff member was not see or hear the client leave to any safety checks completed to any safety checks completed to any actions taken on the facility of the staff member was not see or hear the client leave to any safety checks completed to any actions taken on the facility of the facility of the facility of the facility of the staff member was not see or hear the client leave to any safety checks completed to any actions taken on the facility of the				

Minnesota Department of Health

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPLETED		
H35475		B. WING		C 01/04/2021		
					1 0170	7-17-10-1
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAZEL S	SENIOR LIVING LLC		EL STREET UL, MN 551			
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	O THE APPROPRIATE COMPLE DATE	
0 865	at 6:02 a.m., as "clie-6:00 a.m. monitori ULP-E at 7:01 a.m., -7:00 am. monitorir at 7:02 a.m., as "no-8:00 am. monitorir-9:00 a.m. monitorir-10:00 a.m. monitorir-10:00 a.m. monitorir-10:00 a.m. monitorir-11:00 a.m. mon	ent is in room"; ng was documented by ULP-F ent is in room"; ng was documented by , as "not home"; ng was not documented; ng was not documented; ring was not documented; ring was documented by a., as "not home"; and ring was documented by a., as "not home". cumented completing hourly as "not home". cumented completing any of ecks. dated November 16, 2020, death "Hypothermia due to "Abrasions of the left and on December 8, 2020 at p.m., C1's family member ovember 15, 2020 at a.m., the facility called to ed away. The facility told indered out of the facility and clier that morning. FM-G was e facility video footage, C1 got 2:30 a.m. and then was not eamera. The staff person on	0 865	DEFICIENCY)		
	duty was sleeping. FM-G stated the police officer told her there was a small amount of blood on the facility steps, but the client was found lying in a dirt pile. FM-G stated C1 should have been on every hour checks because he attempted to get out of the facility several times prior to this					

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H35475	B. WING		01/0) 4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAZEL SI	ENIOR LIVING LLC		EL STREET UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	was unlocked from but the side door had an	ed she was told the front door the inside and had no alarm, and a lock and alarm on. on December 11, 2020, at p.m., medical examiner (ME)-rrived at the facility on p. C1 had been moved into the was set up blowing on him. In a scrape on his extremities there was a small amount of teps of the facility. C1's divere located outside near as found. ME-H stated it was be C1's time of death due to the ne client. on December 14, 2020, at p.m., operations manager lovember 15, 2020, she at approximately 9:30 a.m. the dirt near where she parks inployee carried C1 into the alled the facility registered ected to call 911. OM-B stated exted to call 911. OM-B stated she possibly still alive and they be compared to the compared C1 was tated the front door of the ked from the outside and there a door to alert staff if someone M-B stated staff were				

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NAME OF PROVIDER OR SUPPLIER HAZEL SENIOR LIVING LLC TOS HOS PROVIDER OR SUPPLIER HAZEL SENIOR LIVING LLC TOS HOS PROVIDER OR SUPPLIER HAZEL SENIOR LIVING LLC TOS HOS PROVIDER OR SUPPLIER THE SENIOR LIVING LLC TOS HOS PROVIDER OR SUPPLIER THE SENIOR LIVING LLC TOS HOS PROVIDER OR SUPPLIER THE SENIOR LIVING LLC TOS HOS PROVIDER OR SUPPLIER THE SENIOR LIVING LLC TOS HOS PROVIDER SPAN OF CORRECTION PREFIX PREFIX PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PROVIDERS PR	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
HAZEL SENIOR LIVING LLC 109 HAZEL STREET NORTH SAINT PAUL, MN 55119			H35475	B. WING					
MAZEL SENIOR LIVING LLC SAINT PAUL, MN 55119 CALL DEPTICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEPTICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEPTICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEPTICIENCY)	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
SAINT PAUL, MN 55119 PREFIX SUMMARY STATEMENT OF DEFICIENCIES 1		1109 HAZEL STREET NORTH							
REGULATORY OR LSC IDENTIFYING INFORMATION) 0 885 Continued From page 16 RN-D stated C1's hourly checks were to be completed and documented even in the overnight hours when the client was sleeping. RN-D stated the front door did not lock from the inside or have an alarm on it. RN- D confirmed the door did lock from the outside, so re-entry was not possible without a badge. RN-D stated she had observed C1 attempting to leave the facility through the front door did polar before in the past. RN-D stated on November 15, 2020, at approximately 8:00 a. no. ULP-E, she was not aware of C1 going to the hospital and instructed staff to search for him. During an interview on December 15, 2020, at approximately 2:00 p.m., untill November 14, from 2:00 p.m., untill November 14, from 2:00 p.m., untill November 17, 1020, 00 p.m., until November 17, 1020, 600 a. mo. ULP - E stated late in the evening (unsure of the time) C1 became agitated and was trying to go upstairs. ULP-F attempted to redirect C1. He continued to be agitated and was talking in his homeland language (Hmong). ULP-E was unable to understand C1 (speaking in his homeland language) so she texted the operations manager and the registered nurse but received no response. Eventually ULP-F was able to get C1 to go into his room and he shut the door. ULP-F stated she was told she could sleep overnight since she was working so many hours and she fell asleep around 5:00 a.m. and did not check on and/or observe C1 prior to completing her shift and leaving the facility at approximately 6:20 a.m. on November 15, 2020.	HAZEL S	SENIOR LIVING LLC	SAINT PA	UL, MN 551	19				
RN-D stated C1's hourly checks were to be completed and documented even in the overnight hours when the client was sleeping. RN-D stated the front door did not lock from the inside or have an alarm on it. RN-D confirmed the door did lock from the outside, so re-entry was not possible without a badge. RN-D stated she had observed C1 attempting to leave the facility through the front door in the past. RN-D stated on November 15, 2020, at approximately 8:00 a.m. ULP-E notified her C1 could not be found and asked if he went to the hospital. RN-D told ULP-E, she was not aware of C1 going to the hospital and instructed staff to search for him. During an interview on December 15, 2020, at approximately 2:00 p.m., unlicensed personal (ULP)-F, stated she was working a double shift from November 14, from 2:00 p.m., until November 15, 2020, 6:00 a.m. ULP - F stated late in the evening (unsure of the time) C1 became agitated and was trying to go upstairs. ULP-F attempted to redirect C1. He continued to be agitated and was talking in his homeland language (Hmong). ULP-F was unable to understand C1 (speaking in his homeland language) os she texted the operations manager and the registered nurse but the ceived no response. Eventually ULP-F was able to get C1 to go into his room and he shut the door. ULP-F stated she was working so many hours and she fell askep around 2:00 a.m. to 3:00 a.m. ULP-F stated she was told she could sleep overnight since she was working so many hours and she fell askep around 2:00 a.m. to 3:00 a.m. ULP-F stated she woke up around 5:00 a.m. and did not check on and/or observe C1 prior to completing her shift and leaving the facility at approximately 6:20 a.m. on November 15, 2020.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE		
p.m., ULP-C stated on November 15, 2020, C1	0 865	RN-D stated C1's h completed and door hours when the clie the front door did not an alarm on it. RN-from the outside, so without a badge. R C1 attempting to least front door in the past 15, 2020, at approximate her C1 coul went to the hospital not aware of C1 goi instructed staff to see the from November 14, November 15, 2020 (ULP)-F stated she from November 15, 2020 (ate in the evening (became agitated and ULP-F attempted to be agitated and was language (Hmong). Understand C1 (spellanguage) so she to and the registered in the registered in the response. Eventual go into his room and stated she was told since she was work fell asleep around 2 stated she woke up check on and/or obtained in the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language) and the registered in the evening (became agitated and was language)	ourly checks were to be umented even in the overnight nt was sleeping. RN-D stated of lock from the inside or have D confirmed the door did lock ore-entry was not possible N-D stated she had observed ave the facility through the st. RN-D stated on November imately 8:00 a.m. ULP-E d not be found and asked if he RN- D told ULP-E, she was ng to the hospital and earch for him. on December 15, 2020, at p.m., unlicensed personal was working a double shift from 2:00 p.m., until 0, 6:00 a.m. ULP - F stated funsure of the time) C1 and was trying to go upstairs. In redirect C1. He continued to stalking in his homeland ULP-F was unable to eaking in his homeland exted the operations manager nurse but received no be always to get C1 to do he shut the door. ULP-F she could sleep overnight around 5:00 a.m. to 3:00 a.m. ULP-F around 5:00 a.m. and did not serve C1 prior to completing the facility at approximately other 15, 2020. December 15, 2020, at 2:20						

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		D WING		С	
	H35475	B. WING		01/0	4/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HAZEL SENIOR LIVING LLC		EL STREET UL, MN 551			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
ground outside the carried C1 inside the ULP-C thought C1 is of they put him by a C stated C1 had attended the facility multiple to able to redirect him aware C1 was at ris hourly safety check client. During interview on a.m., executive direct November 15, 2020 the operations man was found outside a stated earlier that mocate C1 and his bound outside and did not a through the door. The outside and an are-enter. ED-A states be checked on ever wandering, and states gotten outside the facilities policie regarding safety chevulnerable adult we from the facility. No further informations.	ximately 9:30 a.m. lying on the facility. ULP-C stated when he e facility, his body was rigid. had a pulse and respirations a heater to warm him up. ULP tempted to wander away from times in the past but staff were. ULP-C stated staff were sk for elopement, which is why is were completed on the December 16, 2020, at 10:00 ector (ED)-A stated on 0, at approximately 9:30 a.m. ager called and told her C1 and he was really cold. ED-A norning staff were not able to ed was still made. ED-A or did not have a lock on the larm when someone exited the front door was locked from access card is needed to ed C1 had been assessed to be december of the had acility on November 15, 2020. The sin place prior to the incident ecks, elopement, and re requested but not provided	0 865			

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Minnesota Department of Health STATE FORM