Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL354735001M
Compliance #: HL35475002C

Date Concluded: January 6, 2021

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 1 ½ 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H35475	A. BUILDING: _____ B. WING _____	C 01/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL SENIOR LIVING LLC	1109 HAZEL STREET NORTH SAINT PAUL, MN 55119

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On December 3, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL35475002C/#HL35475001M. At the time of the survey, there were #8 clients receiving services under the comprehensive license. 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 investigation. The following immediate correction order is issued/orders are issued for #HL35475002C/#HL35475001M, tag identification 0265 and 0325 and 0865.	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).	
0 265 SS=J	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice	0 265		

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0 265	Continued From page 1 Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the care and services were provided according to a suitable, and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of one client (C1) reviewed. C1 had a history of eloping and was assessed to be at risk for elopement. C1 eloped from the facility and was found outside the facility, approximately seven hours after last being seen by staff. C1 died from hypothermia. This practice resulted in a level four violation (a violation that results in 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). Findings include: The licensee failed to develop and implement consistent interventions to prevent client #1 from eloping from the facility's unlocked, unalarmed	0 265		

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0 265	Continued From page 2 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, three times daily; behavior management, aggression three times per day; behavior management, agitation, three times daily. Although C1's assessment indicated safety checks every two hours, and the physician orders indicated safety checks hourly, the service plan	0 265		

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0 265	Continued From page 3 did not reflect the clients assessed needs. 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; and - November 1, 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 did not think C1 was in the hospital and staff should look for the client. The operations manager arrived at the facility at 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	0 265		

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0 265	Continued From page 4 operations manager stated when C1 was found outside the facility he was cold to the touch and staff believed he may have been breathing. When staff brought C1 into the facility his clothes were wet and he was covered 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. The day staff member (started at 6:00 a.m. on November 15, 2020) had assumed C1 was in the hospital because his bed was still made and he wasn't in his room. C1 was on hourly safety checks, however, the evening/ overnight staff, unlicensed personal (ULP)-F, was asleep on the overnight of November 15, 2020, so C1's safety checks were not completed. The investigation indicated the facility security footage showed C1's pants were soaked prior to exiting the facility. Because the staff member was sleeping, she did not see or hear the client leave the facility, nor were any safety checks completed for C1. The facility lacked documentation of the facility staff's search for C1 or any actions taken on November 15, 2020, from 8:00 a.m., to 9:30 a.m. (1 1/2 hours). The "R-Task" documentation of hourly checks for C1's activity to ensure his safety, dated November 15, 2020, from 12:00 a.m. until 9:30 a.m., indicated: - 12:00 midnight monitoring was documented by ULP-F at 11:33 p.m., as "client is in room". - 1:00 a.m., monitoring was documented by ULP-F at 5:51 a.m., as "client is in room"; - 2:00 a.m. monitoring was documented by ULP-F at 5:55 a.m., as "client is in room"; - 3:00 a.m. monitoring was documented by ULP-F at 5:59 a.m., as "client is in room";	0 265		

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0 265	Continued From page 5 - 4:00 a.m. monitoring was documented by ULP-F at 6:00 a.m., as "client is in room"; - 5:00 a.m. monitoring was documented by ULP-F at 6:02 a.m., as "client is in room"; - 6:00 a.m. monitoring was documented by ULP-E at 7:01 a.m., as "not home"; - 7:00 am. monitoring was documented by ULP-E at 7:02 a.m., as "not home"; - 8:00 am. monitoring was not documented; - 9:00 a.m. monitoring was not documented; - 10:00 a.m. monitoring was documented by ULP-E at 12:47 p.m., as "not home"; and - 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	0 265		

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0 265	Continued From page 6 out of the facility several times prior to this incident. FM-G stated she was told the front door was unlocked from the inside and had no alarm, but the side door had a lock and alarm on. During an interview on December 11, 2020, at approximately 2:30 p.m., medical examiner (ME)-H stated when he arrived at the facility on November 15, 2020, C1 had been moved into the facility and a heater was set up blowing on him. ME-H stated C1 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. C1's slippers were off and were located outside near the site the client was found. ME-H stated it was difficult to determine C1's time of death due to the heater blowing on the client. During an interview on December 14, 2020, at approximately 3:45 p.m., operations manager (OM)- B stated on November 15, 2020, she arrived at the facility at approximately 9:30 a.m. She saw C1 lying in the dirt near where she parks her car. Another employee carried C1 into the facility. The staff called the facility registered nurse and were directed to call 911. OM-B stated they thought C1 was possibly still alive and they tried to warm C1 up. OM-B stated when the paramedics arrived they stated C1 was deceased. OM-B stated the front door of the facility was only locked from the outside and there was no alarm on the door to alert staff if someone exited the facility. OM-B stated staff were instructed to check on C1 every hour. During an interview on December 15, 2020 at 10:10 a.m. registered nurse (RN)- D stated C1 had a history of wandering out of the previous facility. C1 was assessed to require every two hour checks but the staff were trained to	0 265		

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0 265	Continued From page 7 complete hourly checks to reduce the risk of elopement. 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) 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 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.	0 265		

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0 265	Continued From page 8 During interview on December 15, 2020, at 2:20 p.m., ULP-C stated on November 15, 2020, C1 was found at approximately 9:30 a.m. lying on the ground outside the facility. ULP-C stated when he carried C1 inside the facility, his body was rigid. ULP-C thought C1 had a pulse and respirations so they put him by a heater to warm him up. ULP C stated C1 had attempted to wander away from the facility multiple times in the past but staff were able to redirect him. ULP-C stated staff were aware C1 was at risk for elopement, which is why hourly safety checks were completed on the client. During interview on December 16, 2020, at 10:00 a.m., executive director (ED)-A stated on November 15, 2020, at approximately 9:30 a.m. the operations manager called and told her C1 was found outside and he was really cold. ED-A stated earlier that morning staff were not able to locate C1 and his bed was still made. ED-A stated the front door did not have a lock on the inside and did not alarm when someone exited through the door. The front door was locked from the outside and an access card is needed to re-enter. ED-A stated C1 had been assessed to be checked on every hour because of his risk for wandering, and staff were not aware he had gotten outside the facility on November 15, 2020. The facilities policies in place prior to the incident regarding safety checks, elopement, and vulnerable adult were requested but not provided from the facility. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 265		

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0 325	Continued From page 9	0 325		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) 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 interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 eloped in inclement weather while dressed inappropriately. C1 died from hypothermia. Findings include: On December 23, 2020, 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.	0 325	No Plan of correction is required for 0325, please refer to the public maltreatment report for details.	
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are	0 865		

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0 865	Continued From page 10 first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide services based on the individual client needs identified in the nursing assessment for 1 of 1 clients (C1) reviewed. Safety checks were not completed as assessed. This resulted in actual harm when C1 eloped from the facility in inclement weather while dressed inappropriately. C1died from hypothermia.. This practice resulted in a level three violation (a	0 865		

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0 865	Continued From page 11 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). Findings include: 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, three times daily; behavior management, aggression three times per day; behavior management, agitation, three times daily. Although C1's assessment indicated safety checks every two hours, and the physician orders indicated safety checks hourly, the service plan did not reflect the clients assessed needs.	0 865		

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0 865	Continued From page 12 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; and - November 1, 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 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	0 865		

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0 865	Continued From page 13 outside the facility he was cold to the touch and staff believed he may have been breathing. When staff brought C1 into the facility his clothes were wet and he was covered 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. The day staff member (started at 6:00 a.m. on November 15, 2020) had assumed C1 was in the hospital because his bed was still made and he wasn't in his room. C1 was on hourly safety checks, however, the evening/ overnight staff, unlicensed personal (ULP)-F, was asleep on the overnight of November 15, 2020, so C1's safety checks were not completed. The investigation indicated the facility security footage showed C1's pants were soaked prior to exiting the facility. Because the staff member was sleeping, she did not see or hear the client leave the facility, nor were any safety checks completed for C1. The facility lacked documentation of the facility staff's search for C1 or any actions taken on November 15, 2020, from 8:00 a.m., to 9:30 a.m. (1 1/2 hours). The "R-Task" documentation of hourly checks for C1's activity to ensure his safety, dated November 15, 2020, from 12:00 a.m. until 9:30 a.m., indicated: - 12:00 midnight monitoring was documented by ULP-F at 11:33 p.m., as "client is in room". - 1:00 a.m., monitoring was documented by ULP-F at 5:51 a.m., as "client is in room"; - 2:00 a.m. monitoring was documented by ULP-F at 5:55 a.m., as "client is in room"; - 3:00 a.m. monitoring was documented by ULP-F at 5:59 a.m., as "client is in room"; - 4:00 a.m. monitoring was documented by ULP-F	0 865		

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0 865	Continued From page 14 at 6:00 a.m., as "client is in room"; - 5:00 a.m. monitoring was documented by ULP-F at 6:02 a.m., as "client is in room"; - 6:00 a.m. monitoring was documented by ULP-E at 7:01 a.m., as "not home"; - 7:00 am. monitoring was documented by ULP-E at 7:02 a.m., as "not home"; - 8:00 am. monitoring was not documented; - 9:00 a.m. monitoring was not documented; - 10:00 a.m. monitoring was documented by ULP-E at 12:47 p.m., as "not home"; and - 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 out of the facility several times prior to this	0 865		

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0 865	Continued From page 15 incident. FM-G stated she was told the front door was unlocked from the inside and had no alarm, but the side door had a lock and alarm on. During an interview on December 11, 2020, at approximately 2:30 p.m., medical examiner (ME)-H stated when he arrived at the facility on November 15, 2020, C1 had been moved into the facility and a heater was set up blowing on him. ME-H stated C1 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. C1's slippers were off and were located outside near the site the client was found. ME-H stated it was difficult to determine C1's time of death due to the heater blowing on the client. During an interview on December 14, 2020, at approximately 3:45 p.m., operations manager (OM)- B stated on November 15, 2020, she arrived at the facility at approximately 9:30 a.m. She saw C1 lying in the dirt near where she parks her car. Another employee carried C1 into the facility. The staff called the facility registered nurse and were directed to call 911. OM-B stated they thought C1 was possibly still alive and they tried to warm C1 up. OM-B stated when the paramedics arrived they stated C1 was deceased. OM-B stated the front door of the facility was only locked from the outside and there was no alarm on the door to alert staff if someone exited the facility. OM-B stated staff were instructed to check on C1 every hour. During an interview on December 15, 2020 at 10:10 a.m. registered nurse (RN)- D stated C1 had a history of wandering out of the previous facility. C1 was assessed to require every two checks but the staff were trained to complete hourly checks to reduce the risk of elopement.	0 865		

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0 865	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 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) 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 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. During interview on December 15, 2020, at 2:20 p.m., ULP-C stated on November 15, 2020, C1	0 865		

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0 865	Continued From page 17 was found at approximately 9:30 a.m. lying on the ground outside the facility. ULP-C stated when he carried C1 inside the facility, his body was rigid. ULP-C thought C1 had a pulse and respirations so they put him by a heater to warm him up. ULP C stated C1 had attempted to wander away from the facility multiple times in the past but staff were able to redirect him. ULP-C stated staff were aware C1 was at risk for elopement, which is why hourly safety checks were completed on the client. During interview on December 16, 2020, at 10:00 a.m., executive director (ED)-A stated on November 15, 2020, at approximately 9:30 a.m. the operations manager called and told her C1 was found outside and he was really cold. ED-A stated earlier that morning staff were not able to locate C1 and his bed was still made. ED-A stated the front door did not have a lock on the inside and did not alarm when someone exited through the door. The front door was locked from the outside and an access card is needed to re-enter. ED-A stated C1 had been assessed to be checked on every hour because of his risk for wandering, and staff were not aware he had gotten outside the facility on November 15, 2020. The facilities policies in place prior to the incident regarding safety checks, elopement, and vulnerable adult were requested but not provided from the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 865		