Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202683883M
Compliance #: HL202686402C

Date Concluded: January 24, 2023

Name, Address, and County of Licensee Investigated:
Central Minnesota Senior Care
115 4th Avenue South
Brownton, MN, 55312
McLeod County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator
Rhylee Gilb, RN
Investigator Supervisor

Finding: Substantiated, facility and individual 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.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to provide supervision which resulted in the resident being outside for an extended period causing hypothermia (low body temperature).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. Facility staff were aware the resident was outside for over three hours in cold temperatures without proper clothing. The facility failed to identify the resident's risks of injury from cold weather and failed to obtain medical care for the resident in a timely manner. The resident eloped from the facility multiple times prior to this incident. The AP failed to assess the resident, update his care plan with elopement interventions, and direct unlicensed personnel (ULP) how to provide cares related to the resident's behaviors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of resident's records, employee files, internal investigations, incident reports, and facility policies. Also, the investigator observed toured the facility and observed interactions for staff and residents.

The resident resided in an assisted living facility for diagnoses including dementia and bipolar disorder. The resident's service plan included assistance with medication administration, bathing, dressing, and grooming. The service plan indicated the resident required behavior monitoring and safety checks every two hours.

The resident's hospital discharge summary prior to admission to the facility indicated he had psychiatric deterioration pending an inpatient psychiatric admission. The resident had issued with agitation and hallucinations.

The facility's pre-admission assessment, completed by the AP (the facility RN), failed to include the resident's history of behaviors. The facility's Uniform Disclosure of Assisted Living Services Available, indicated the facility did not provide services for wandering or exit seeking behaviors, nor have services to manage challenging behaviors.

During an interview, a family member said the resident required a safe environment and the facility staff said they could provide a safe place for him.

The resident's admission assessment, completed by the AP, indicated he had behaviors of physical and verbal violence; however, no interventions were identified. Additionally, the residents Individual Abuse Prevention Plan (IAPP), updated a month after admission, did not indicate any wandering or self-injurious behaviors with interventions.

Approximately two months after admission, the resident's progress notes indicated several elopements from the facility and persistent delusion of someone coming to pick him up from the facility, he would pack his bags of clothes and wait outside. The resident had five documented elopements in a two-month span. One elopement, unlicensed personnel (ULP) staff found the resident at a near by local school, believing he had a girlfriend at the high school. The second elopement, ULP staff found the resident at a meat market, located a block away, attempting to get into someone's car. The third elopement, just days later, ULP staff found the resident across the street attempting to get into the neighbor's car. The fourth elopement, ULP staff found the resident outside looking for mints. The fifth elopement, ULP staff allowed the resident to be outside unsupervised and when they returned to check on him, the ULP could not find him. The ULP called 911 and five to 10 minutes later when law enforcement arrived, the resident was found back on the facility premises sitting on a swing.

Additionally, during the two-month span of elopements, the resident's progress notes indicated several days of delusional and aggressive behaviors including exit seeking, packing his belongs and standing outside much of the day waiting for someone to pick up, refusing to go inside. Another note, indicated on day the resident spent most of his day outside with intermittent supervision, ULP staff found the resident defecating outside and required a shower by staff. When the resident had been outside, ULP staff wrote they notified the neighbors to keep their car locked "just in case." Also, one incident report indicated the resident had an altercation with two other residents, cursed at one of the residents and "smacked" her in the mouth several times.

The AP completed a 90-day assessment of the resident during this time and failed to include four of the five documented elopements and had no additional behavioral changes from the initial admission assessment. The AP did not identify and implement any additional interventions to address the residents wandering, elopements and aggressive behaviors. The AP failed to assess the resident's vulnerabilities, including self-injurious behaviors of eloping, and implement interventions to keep the resident and other residents safe. The resident's IAPP remained unchanged. There was no documentation the resident's physician was updated regarding his persistent behaviors to address any needed medication changes.

The resident's progress notes lacked any record for nearly a month.

The resident's next progress note entry and incident report indicated the residents was outside at the end of November, when the temperature was 3 degrees outside. The resident refused to go inside and was outside for over three hours. ULP 1 documented the resident was emotional and yelled at staff. ULP 1, indicated the resident had been outside prior to her start of her 3:00 p.m. shift. ULP 1, called the house manager (who was another unlicensed staff) to report the resident's refusal. The house manager instructed ULP 1, "eventually he'll come inside." An hour later, ULP 1 called the nurse on-call who instructed her to call 911. ULP 1 called 911 around 6:00 p.m. and the resident transported with emergency medical services to the hospital.

During an interview, ULP 1 said the resident was outside when she arrived for work at 3:00 pm. She attempted to get the resident inside, but he refused. ULP 1 said the resident was wearing a yellow shirt, sweatpants, shoes, and a leather jacket. ULP 1 said the resident was not wearing a hat or gloves. ULP 1 said she made multiple attempts to get the resident inside because it was cold and windy. ULP 1 said she called a member of leadership at approximately 5:30 p.m., who told her to wait forty-five minutes, then call a nurse. ULP 1 said the resident was shivering, and his hands were red. ULP 1 said she called the nurse at approximately 6:00 p.m. that evening and the nurse instructed her to call 911. ULP 1 said 911 responders came to the facility at approximately 6:40 p.m. and took the resident to the hospital.

During an interview, ULP 2 said the resident left the facility in the afternoon, but she was unsure of the exact time, but thought it was not long before 3:00 p.m. ULP 2 said the resident went outside because he thought his wife was picking him up.

The resident's hospital records indicated the resident's body temperature was 87.3 degrees during transfer to the hospital. Hospital records indicated the resident's hands were cool, discolored, and his feet were "very" cold. Hospital records indicated his pulses were not palpable (able to be felt), he was stuporous and shivering. The resident admitted to the hospital for hypothermia (critically low body temperature).

During an interview, the manager said she was not aware of the incident until the following day. The manager said the resident has a diagnosis of dementia. The manager said the resident should not have been outside for as long as he was.

During an interview, the AP said she was at the facility once a week. The AP said she is responsible for doing the resident's assessments. The AP said she reviews all the resident's progress notes and incident reports. She previously reviewed progress notes every three months, but since the resident's hospitalization she now reviews progress notes every month. The AP said she was aware the resident had left the facility "a few times". The AP said she put no other interventions in place for staff to maintain the resident's safety. The AP said she was aware the resident had attempted to get into other people's vehicles. The AP made no other changes to the resident's care plan. The AP said she was aware the resident had a physical altercation with another resident. The AP said she made no other changes to the resident's care plan. The AP said she did not notify the residents physician about his increased confusion or aggression. The AP said she did not report the incidents (as required by mandated reporters) because she thought it was the manager's job and she trusted her judgement. The AP said it was the responsibility of unlicensed personnel (ULP) to update IAPP assessments and interventions (although that is beyond the scope of practice and required by only an RN).

At the time of the onsite visit, the resident was still hospitalized and unable to be interview. Family indicated they did not want the resident to return to the facility. Hospital notes indicated physician's advised finding new placement for the resident with a secure locked memory care unit.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

"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.

Vulnerable Adult interviewed: No. Resident was unable to participate.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility provided education to staff and implemented a cold weather policy.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
McLeod County County Attorney
Brownton City Attorney
Brownton Police Department
Minnesota Board Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20268	A. BUILDING: _____ B. WING _____	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	115 4TH AVENUE SOUTH BROWNTON, MN 55312

(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****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: **REVISED** #HL202686402C/#HL202683883M On December 8, 2022 through December 12, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL202686402C/#HL202683883M, tag identification 620, 630, 160, 2360, and 300. The immediate correction order, tag 2310 was corrected on December 12, 2022.	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 Assisted Living License 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 144G.31 subd. 1, 2, and 3.	
0 620 SS=H	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse; failed to notify emergency contact of resident-to-resident physical abuse, and failed to complete a thorough investigation for occurrences of suspected abuse and neglect for three of four residents (R1, R2, R4,) reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's medical record indicated R1 received services for diagnoses including dementia associated with alcoholism, bipolar disorder, atrial	0 620		

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0 620	Continued From page 2 fibrillation, chronic anticoagulation, diabetes, and hypoxia. R1's service plan dated June 27, 2022, indicated he required assistance with medication administration, oxygen, meal preparation, bathing, dressing, grooming, and housekeeping. The service plan indicated R1 required behavior monitoring and safety checks every two hours. R1's progress note dated September 5, 2022, indicated at 4:20 a.m., the facility door alarm sounds. Staff found R1 outside near a local school. R1 had delusions his girlfriend was at the high school and attempted to elope again after getting back inside the facility. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress notes dated September 12, 2022, indicated R1 eloped from the facility and was located at a "meat market" in someone's car. (Map review indicated approximately one block away from the facility). The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress notes dated September 16, 2022, indicated R1 eloped from the facility and was found across the street attepting to get into a neighbor's car. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress note dated October 29, 2022, indicated R1 eloped the facility and was found outside looking for mints. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report.	0 620		

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0 620	Continued From page 3 R1's progress note dated November 1, 2022, indicated ULP allowed R1 to go outside. When the ULP went to check on him, he was gone and unable to be found. The ULP called 911. When law enforcement arrived five to 10 minutes later, R1 was back on the facility premises outside on a swing. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress notes dated November 30, 2022, indicated R1 was outside for over three hours. R1's progress notes indicated the temperature was three degrees outside. R1's notes indicated he was emotional, yelled at staff, and refused to go inside. ULP-C called the house manager, who instructed them "eventually he'll come inside". An hour later, ULP-C called the nurse who instructed her to call 911. ULP-C called 911 and R1 transported to the hospital. The licensee failed to submit a MAARC report. R1's hospital records dated November 30, 2022, at 8:56 p.m., indicated R1's body temperature was 87.3 degrees during transfer to the hospital. Hospital records indicate R1's hands were cool. R1's feet were "very" cold, and pulses were not palpable. Hospital records indicated R1 was stuporous and shivering. Hospital records indicate R1 admitted to the hospital with a diagnosis of hypothermia. R2 R2's medical record indicated R2 received services for diagnosis of failure to thrive. R2's service plan dated August 22, 2022, indicated she required assistance with medication administration, meal preparation, dressing, grooming, bathing, laundry, and housekeeping.	0 620		

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0 620	Continued From page 4 The service plan indicated R2 required behavior monitoring three times daily. Incident report dated October 23, 2022, indicated R2 "ran out of his medications". The report indicated R2 failed to receive medication for over three days. The report indicated R2's blood pressure was high and required emergency responders to take him to the hospital. The report indicated there were three medications R2 required. The report indicated R2 ran out of medication because he did not have a primary doctor. The incident report indicated RN-I reviewed the incident report on October 24, 2022. The licensee failed to submit a MAARC report for the incident on October 23, 2022. R4 R4's medical record indicated R4 received services for diagnoses including schizoaffective disorder, bipolar disorder, and personality disorder. R4's service plan dated February 18, 2021, indicated she required assistance with medication administration, meal preparation, bathing, dressing, grooming, laundry, and housekeeping. The service plan indicated R4 required behavior monitoring three times daily and safety checks every two hours during the night. Incident report dated October 14, 2022, at 8:15 p.m., indicated R1 was arguing with R2 and R4. The report indicated R1 went toward R4 and told her, "Shut the fuck up you bitch". The report indicated R1 "smacked" her in the mouth four times. The licensee failed to investigate the incident and submit a MAARC report.	0 620		

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0 620	Continued From page 5 During an interview on December 12, 2022, at 12:13 p.m., AD-B and RN-I acknowledged that MAARC reports should have been completed and incidents should have been investigated. The licensee's, Reporting of Maltreatment of Vulnerable Adults, policy dated January 25, 2019, indicated a MAARC report would be completed immediately after a vulnerable adult was maltreated. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=H	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (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 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) were developed to include statements of the specific measures to be taken to minimize the risk of abuse for three of four residents (R1, R2, R4) reviewed.	0 630		

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0 630	Continued From page 6 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's medical record was reviewed. R1 admitted on June 27, 2022, for diagnoses including dementia associated with alcoholism, bipolar disorder, atrial fibrillation, chronic anticoagulation, diabetes, and hypoxia. R1's service plan dated June 27, 2022, indicated he required assistance with medication administration, oxygen, meal preparation, bathing, dressing, grooming, and housekeeping. R1's service plan indicated he required behavior monitoring and safety checks every two hours. R1's admission assessment dated June 28, 2022, indicated he required safety checks every two hours. R1's assessment indicated he had behaviors of physical and verbal violence. R1's assessment indicated he was confused from a diagnosis of dementia due to alcoholism. R1's IAPP dated July 28, 2022, failed to identify R1's risk of abusing other vulnerable adults. The IAPP failed to identify individualized interventions for reducing risk of abuse to other vulnerable adults. R1's progress note dated September 5, 2022,	0 630		

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0 630	Continued From page 7 indicated at 4:20 a.m., the facility door alarm sounds. Staff found R1 outside near a local school. R1 had delusions his girlfriend was at the high school and attempted to elope again after getting back inside the facility. R1's progress note dated September 6, 2022, indicated R1 set off the facility door alarm, wandering back and forth between the front door and back door. R1's progress note dated September 7, 2022, indicated R1 continued to have a delusion he was getting picked up to leave. R1's progress notes dated September 12, 2022, indicated R1 eloped from the facility and was located at a "meat market" in someone's car. (Map review indicated approximately one block away from the facility). R1's progress notes dated September 16, 2022, indicated R1 eloped from the facility and was found across the street attepting to get into a neighbor's car. Incident report dated October 14, 2022, at 8:15 p.m., indicated R1 was arguing with R2 and R4. The report indicated R1 went toward R4 and told her, "Shut the fuck up you bitch". The report indicated R1 "smacked" her in the mouth four times. R1's progress note dated October 29, 2022, indicated R1 eloped the facility and was found outside looking for mints. R1's progress note dated October 30, 2022, indicated unlicensed personnel (ULP) allowed R1 to go outside unsupervised because he wanted to	0 630		

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0 630	Continued From page 8 be outside. Upon checking on R1, staff found R1 deficating outside by a van. Staff allowed R1 to go back outside after receiving a shower two more times indicated intermittent supervision. R1's progress note dated November 1, 2022, indicated ULP allowed R1 to go outside. When the ULP went to check on him, he was gone and unable to be found. The ULP called 911. When law enforcement arrived five to 10 minutes later, R1 was back on the facility premises outside on a swing. R1's progress note dated November 2, 2022, indicated R1 was outside with all of his bloths and threatened to throw a rock at the ULP. R1 had been outside "all day" and ULP staff told the neighbors to keep their car locked "just in case". R1's progress note dated November 3, 2022, indicated R1 had been outside "most of the day" with all of his clothes and had a delusions someone is coming to pick him up. R1's record lacked progress notes between November 3, 2022 through November 29, 2022. R1's progress notes dated November 30, 2022, indicated R1 was outside for over three hours. R1's progress notes indicated the temperature was three degrees outside. R1's notes indicated he was emotional, yelled at staff, and refused to go inside. ULP-C called the house manager, who instructed them "eventually he'll come inside". An hour later, ULP-C called the nurse who instructed her to call 911. ULP-C called 911 and R1 transported to the hospital. R1's hospital records dated November 30, 2022, at 8:56 p.m., indicated R1's body temperature	0 630		

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	20268	A. BUILDING: _____ B. WING _____	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	115 4TH AVENUE SOUTH BROWNTON, MN 55312

(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	Continued From page 9 was 87.3 degrees during transfer to the hospital. Hospital records indicate R1's hands were cool. R1's feet were "very" cold, and pulses were not palpable. Hospital records indicated R1 was stuporous and shivering. Hospital records indicate R1 admitted to the hospital with a diagnosis of hypothermia. During record review on December 8, 2022, the licensee was unable provide updated IAPP assessments for R1 since July 28, 2022. Licensee failed to identify R1's risk of self abuse due to elopement history and aggressive behaviors and therefore did not update the plan to include interventions to reduce the risk of self harm or harm towards others for the incidents between September through November 2022. R2's medical record was reviewed. R2 admitted on May 12, 2022, for a diagnosis of failure to thrive. R2's service plan dated August 22, 2022, indicated she required assistance with medication administration, meal preparation, dressing, grooming, bathing, laundry, and housekeeping. R2's service plan indicated she required behavior monitoring three times daily. R2's IAPP dated January 24, 2022, failed to identify R2's risk of abusing other vulnerable adults. The assessment failed to identify individualized interventions to reduce risk of abuse to other vulnerable adults. R2's nursing assessment dated August 29, 2022, indicated she had verbally abusive behaviors. R2's assessment indicated she said she, "should beat the other resident's ass". R2's assessment indicated she required safety checks every two	0 630		

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0 630	Continued From page 10 hours. Facility incident report dated October 14, 2022, at 8:15 p.m., indicated R2 was in a verbal altercation with R1 and R4. R2's record lacked an updated IAPP with R2's behaviors towards other and specific interventions to reduce risk of abuse. R4's medical record was reviewed. R4 admitted on February 25, 2022, for diagnoses including schizoaffective disorder, bipolar disorder, and personality disorder. R4's nursing assessment dated August 29, 2022, indicated she had physically violent behaviors and anger outbursts. R4's assessment indicated her behaviors included staff manipulation, throwing herself on the floor, soiling herself, and periods of mania. R4's assessment indicated she required psychotropic medication for behavior management. R4's IAPP dated September 26, 2022, failed to identify her susceptibility to be physically abused by others. The assessment failed to identify R4's risk to abuse other vulnerable adults. The assessment failed to identify individualize interventions to reduce risk of abuse. During an interview on January 3, 2023, at 10:38 a.m., RN-I stated she was responsible for completing resident assessments, however she did not assess resident vulnerabilities as an unlicensed personnel was responsible for creating abuse prevention plans. The licensee's, Initial and Ongoing Client Evaluation and Assessments, no date, indicated	0 630		

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0 630	Continued From page 11 IAPP would be developed and contain individualized assessments of the persons susceptibility to abuse by others and risk of abusing other vulnerable adults. Time period for correction 7 days.	0 630		
01600 SS=G	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to adhere to their Uniform Disclosure of Assisted Living Services and Ammenties (UDALSA) when they admitted one of four residents (R1) that required services beyond what the facility licensee they are able to provide. As a result, R1 had several elopments from the facility and during one elopment R1 became hypothermic (critically low body temperature) outside requiring hospitalization. This practice resulted in a level three violation (a violation that harmed a resident'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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01600		

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01600	Continued From page 12 R1's preadmission registered nurse (RN) assessment, undated, however identifed as completed on June 22, 2022 on the admission assessment, indicated R1 was currently hospitalized. R1's assessment did not indicate any behaviors and wandering was marked as "never". R1's preadmission assessment was completed by RN-I. R1's hospital discharge summary record, dated June 27, 2022, indicated R1 was hospitalized prior to his admission to the licensee. R1's diagnosese included dementia and biploar. Hospital records indicated R1 had psychiatric deterioration pending an inpatient pychiatric admission. R1 had issues with agitation and hallucinations. The licensee's UDALSA dated May 25, 2021. indicated they do not provide services for wandering or exit seeking behaviors nor indicated they did not have services to manage challenging behaviors. R1 admitted on June 27, 2022, for diagnoses including dementia associated with alcoholism, bipolar disorder, atrial fibrillation, chronic anticoagulation, diabetes, and hypoxia. R1's service plan dated June 27, 2022, indicated he required assistance with medication administration, oxygen, meal preparation, bathing, dressing, grooming, and housekeeping. R1's service plan indicated he required behavior monitoring and safety checks every two hours. R1's admission assessment dated June 28, 2022, completed by RN-I, indicated he had behaviors of physical and verbal violence. The assessment indicated he was confused from a	01600		

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01600	Continued From page 13 diagnosis of dementia due to alcoholism. R1's progress note dated September 5, 2022, indicated at 4:20 a.m., the facility door alarm sounds. Staff found R1 outside near a local school. R1 had delusions his girlfriend was at the high school and attempted to elope again after getting back inside the facility. R1's progress note dated September 6, 2022, indicated R1 set off the facility door alarm, wandering back and forth between the front door and back door. R1's progress note dated September 7, 2022, indicated R1 continued to have a delusion he was getting picked up to leave. R1's progress notes dated September 12, 2022, indicated R1 eloped from the facility and was located at a "meat market" in someone's car. (Map review indicated approximately one block away from the facility). R1's progress notes dated September 16, 2022, indicated R1 eloped from the facility and was found across the street attepting to get into a neighbor's car. Incident report dated October 14, 2022, at 8:15 p.m., indicated R1 was arguing with R2 and R4. The report indicated R1 went toward R4 and told her, "Shut the fuck up you bitch". The report indicated R1 "smacked" her in the mouth four times. R1's progress note dated October 29, 2022, indicated R1 eloped the facility and was found outside looking for mints.	01600		

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01600	Continued From page 14 R1's progress note dated October 30, 2022, indicated unlicensed personnel (ULP) allowed R1 to go outside unsupervised because he wanted to be outside. Upon checking on R1, staff found R1 deficating outside by a van. Staff allowed R1 to go back outside after receiving a shower two more times indicated intermittent supervision. R1's progress note dated November 1, 2022, indicated ULP allowed R1 to go outside. When the ULP went to check on him, he was gone and unable to be found. The ULP called 911. When law enforcement arrived five to 10 minutes later, R1 was back on the facility premises outside on a swing. R1's progress note dated November 2, 2022, indicated R1 was outside with all of his bloths and threatened to throw a rock at the ULP. R1 had been outside "all day" and ULP staff told the neighbors to keep their car locked "just in case". R1's progress note dated November 3, 2022, indicated R1 had been outside "most of the day" with all of his clothes and had a delusions someone is coming to pick him up. R1's record lacked progress notes between November 3, 2022 through November 29, 2022. R1's progress notes dated November 30, 2022, indicated R1 was outside for over three hours. R1's progress notes indicated the temperature was three degrees outside. R1's notes indicated he was emotional, yelled at staff, and refused to go inside. ULP-C called the house manager, who instructed them "eventually he'll come inside". An hour later, ULP-C called the nurse who instructed her to call 911. ULP-C called 911 and R1 transported to the hospital.	01600		

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01600	Continued From page 15 R1's hospital records dated November 30, 2022, at 8:56 p.m., indicated R1's body temperature was 87.3 degrees during transfer to the hospital. Hospital records indicate R1's hands were cool. R1's feet were "very" cold, and pulses were not palpable. Hospital records indicated R1 was stuporous and shivering. Hospital records indicate R1 admitted to the hospital with a diagnosis of hypothermia. During an interview on December 12, 2022, at 3:25 p.m., a family member (FM)-F, said R1 required a safe environment. FM- F said licensee confirmed they could provide a safe place and support R1's mental health. FM-F said R1 was then admitted to licensee. During an interview on January 3, 2023, at 10:38 a.m., RN-I stated she was responsible for completing resident assessments, however she did not assess resident vulnerabilities as an unlicensed personnel was responsible for creating abuse prevention plans. RN-I stated R1's common delusion was he was getting married and someone was going to pick him up from the facility. RN-I stated R1 often packed up his bags and going outside. Licensee failed to produce documentation regarding attempts to find alternative safe placement for R1 after he eloped multiple times. TIME PERIOD FOR CORRECTION: 7 days	01600		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 16 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing assessments after elopements and increased delusions for one of four residents (R1) reviwed. As a result, the licensee failed to identify and implement elopment interventions which resulted in R1 requiring hospitalization for hypothermia. This practice resulted in a level three violation (a violation that harmed a resident'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	01620		

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01620	Continued From page 17 issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to licensee on June 27, 2022, for diagnoses including dementia associated with alcoholism, bipolar disorder, atrial fibrillation, chronic anticoagulation, diabetes, and hypoxia. R1's admission assessment dated June 28, 2022, indicated R1 had behaviors of physical and verbal violence. The assessment indicated the resident was confused from a diagnosis of dementia due to alcoholism. R1's progress note dated September 5, 2022, indicated at 4:20 a.m., the facility door alarm sounds. Staff found R1 outside near a local school. R1 had delusions his girlfriend was at the high school and attempted to elope again after getting back inside the facility. R1's progress note dated September 6, 2022, indicated R1 set off the facility door alarm, wandering back and forth between the front door and back door. R1's progress note dated September 7, 2022, indicated R1 continued to have a delusion he was getting picked up to leave. R1's progress notes dated September 12, 2022, indicated R1 eloped from the facility and was located at a "meat market" in someone's car. (Map review indicated approximately one block away from the facility).	01620		

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01620	Continued From page 18 R1's progress notes dated September 16, 2022, indicated R1 eloped from the facility and was found across the street attepting to get into a neighbor's car. R1's record lacked a change in needs assessment regarding R1's elopements and delusions. R1's 90 day assessment, signed by RN-I on October 31, 2022, but indicated completed on October 10, 2022, included under elopement history the event on September 5, 2022, but failed to include the elopements on September 12 and September 16, 2022. R1's interventions had not changed from the previous every two hour safety checks. R1's assessment failed to include any changes in behaviors or mental status from R1's admission assessment. Under the safety section, pattern of wandering was indicated and described "pack his belongings and wait for family outside or by door". R1's assessment failed to indentify any new interventions for wandering. Incident report dated October 14, 2022, at 8:15 p.m., indicated R1 was arguing with R2 and R4. The report indicated R1 went toward R4 and told her, "Shut the fuck up you bitch". The report indicated R1 "smacked" her in the mouth four times. R1's progress note dated October 29, 2022, indicated R1 eloped the facility and was found outside looking for mints. R1's progress note dated October 30, 2022, indicated unlicensed personnel (ULP) allowed R1 to go outside unsupervised because he wanted to be outside. Upon checking on R1, staff found R1 deficating outside by a van. Staff allowed R1 to	01620		

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01620	Continued From page 19 go back outside after receiving a shower two more times indicated intermittent supervision. R1's progress note dated November 1, 2022, indicated ULP allowed R1 to go outside. When the ULP went to check on him, he was gone and unable to be found. The ULP called 911. When law enforcement arrived five to 10 minutes later, R1 was back on the facility premises outside on a swing. R1's progress note dated November 2, 2022, indicated R1 was outside with all of his bloths and threatened to throw a rock at the ULP. R1 had been outside "all day" and ULP staff told the neighbors to keep their car locked "just in case". R1's progress note dated November 3, 2022, indicated R1 had been outside "most of the day" with all of his clothes and had a delusions someone is coming to pick him up. R1's record lacked progress notes between November 3, 2022 through November 29, 2022. R1's progress notes dated November 30, 2022, indicated R1 was outside for over three hours. R1's progress notes indicated the temperature was three degrees outside. R1's notes indicated he was emotional, yelled at staff, and refused to go inside. ULP-C called the house manager, who instructed them "eventually he'll come inside". An hour later, ULP-C called the nurse who instructed her to call 911. ULP-C called 911 and R1 transported to the hospital. R1's hospital records dated November 30, 2022, at 8:56 p.m., indicated R1's body temperature was 87.3 degrees during transfer to the hospital. Hospital records indicate R1's hands were cool.	01620		

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01620	Continued From page 20 R1's feet were "very" cold, and pulses were not palpable. Hospital records indicated R1 was stuporous and shivering. Hospital records indicate R1 admitted to the hospital with a diagnosis of hypothermia. During an interview on January 3, 2023, at 10:38 a.m., RN-I stated she was responsible for completing resident assessments. RN-I stated she was at the facility once a week. RN-I stated she used to review progress notes every three months prior to this incident and now reviews progress notes monthly. The licensee policy titled Initial and Ongoing Client Evaluation and Assessments, undated, and referencing 144A (home care provider) statutes, indicated reassessments will be conducted based on changes in the needs of the resident. A nurse will identify changes in the resident's conditions and work with appropriate health care professionals to manage the residents condition. The changes in the resident's care/condition will be communicated to teh appropriate staff and provider. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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02310	Continued From page 21 Based on observation and interview, the licensee failed to provide safety and security standards for three of three residents (R2, R3, R4) with records reviewed. An alarmed entrance door to the building was propped open and unattended by staff. This resulted in an immediate correction order on December 8, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 received service for diagnosis that included failure to thrive. R3 received services for diagnoses that included falls, chronic pain, and hemiplegia. R4 received services for diagnoses that included schizoaffective disorder, bipolar, and asthma. On December 8, 2022, at 9:15 a.m., the surveyor arrived at the facility and found the front door propped open with no staff insight. The surveyor entered the facility unnoticed. During an interview on December 8, 2022, at 9:30 a.m., unlicensed personnel (ULP)-A acknowledged door was propped open. ULP-A said she was working with another resident and did not hear the surveyor enter. ULP-A said there was a resident who was independently	02310	On December 12, 2022, immediate order corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20268	A. BUILDING: _____ B. WING _____	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	115 4TH AVENUE SOUTH BROWNTON, MN 55312

(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
02310	Continued From page 22 ambulatory and left frequently to smoke. On December 8, 2022, at 2:30 p.m., administrator (AD)-A verbalized the doors should remain closed for safety of all residents. AD-A said each entrance to the facility had alarm system to alert staff when the door was opened. AD-A had witnessed with the surveyor the entrance door propped open a second time. TIME PERIOD FOR CORRECTION: Immediate On December 12, 2022, immediate order corrected. December 12, 2022, at 10:00 a.m., surveyor arrived at licensee and entrance to building was closed. Staff were present and assisted surveyor in entering the building. Staff provided visitor screening upon enter. The licensee provided documentation of staff education and plan of correction.	02310		
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 1 residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include:	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report for details.	

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02360	Continued From page 23 The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the faciliy and an individual staff person were 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		
03000 SS=H	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	03000		

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03000	Continued From page 24 reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse; failed to notify emergency contact of resident-to-resident physical abuse, and failed to complete a thorough investigation for occurrences of suspected abuse and neglect for three of four residents (R1, R2, R4,) reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more	03000		

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03000	Continued From page 25 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's medical record indicated R1 received services for diagnoses including dementia associated with alcoholism, bipolar disorder, atrial fibrillation, chronic anticoagulation, diabetes, and hypoxia. R1's service plan dated June 27, 2022, indicated he required assistance with medication administration, oxygen, meal preparation, bathing, dressing, grooming, and housekeeping. The service plan indicated R1 required behavior monitoring and safety checks every two hours. R1's progress note dated September 5, 2022, indicated at 4:20 a.m., the facility door alarm sounds. Staff found R1 outside near a local school. R1 had delusions his girlfriend was at the high school and attempted to elope again after getting back inside the facility. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress notes dated September 12, 2022, indicated R1 eloped from the facility and was located at a "meat market" in someone's car. (Map review indicated approximately one block away from the facility). The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress notes dated September 16, 2022, indicated R1 eloped from the facility and was found across the street attepting to get into a	03000		

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03000	Continued From page 26 neighbor's car. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress note dated October 29, 2022, indicated R1 eloped the facility and was found outside looking for mints. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress note dated November 1, 2022, indicated ULP allowed R1 to go outside. When the ULP went to check on him, he was gone and unable to be found. The ULP called 911. When law enforcement arrived five to 10 minutes later, R1 was back on the facility premises outside on a swing. The licensee failed to provide an incident report, investigate the incident and submit a MAARC report. R1's progress notes dated November 30, 2022, indicated R1 was outside for over three hours. R1's progress notes indicated the temperature was three degrees outside. R1's notes indicated he was emotional, yelled at staff, and refused to go inside. ULP-C called the house manager, who instructed them "eventually he'll come inside". An hour later, ULP-C called the nurse who instructed her to call 911. ULP-C called 911 and R1 transported to the hospital. The licensee failed to submit a MAARC report. R1's hospital records dated November 30, 2022, at 8:56 p.m., indicated R1's body temperature was 87.3 degrees during transfer to the hospital. Hospital records indicate R1's hands were cool. R1's feet were "very" cold, and pulses were not palpable. Hospital records indicated R1 was stuporous and shivering. Hospital records indicate R1 admitted to the hospital with a	03000		

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03000	Continued From page 27 diagnosis of hypothermia. R2 R2's medical record indicated R2 received services for diagnosis of failure to thrive. R2's service plan dated August 22, 2022, indicated she required assistance with medication administration, meal preparation, dressing, grooming, bathing, laundry, and housekeeping. The service plan indicated R2 required behavior monitoring three times daily. Incident report dated October 23, 2022, indicated R2 "ran out of his medications". The report indicated R2 failed to receive medication for over three days. The report indicated R2's blood pressure was high and required emergency responders to take him to the hospital. The report indicated there were three medications R2 required. The report indicated R2 ran out of medication because he did not have a primary doctor. The incident report indicated RN-I reviewed the incident report on October 24, 2022. The licensee failed to submit a MAARC report for the incident on October 23, 2022. R4 R4's medical record indicated R4 received services for diagnoses including schizoaffective disorder, bipolar disorder, and personality disorder. R4's service plan dated February 18, 2021, indicated she required assistance with medication administration, meal preparation, bathing, dressing, grooming, laundry, and housekeeping. The service plan indicated R4 required behavior monitoring three times daily and safety checks	03000		

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03000	Continued From page 28 every two hours during the night. Incident report dated October 14, 2022, at 8:15 p.m., indicated R1 was arguing with R2 and R4. The report indicated R1 went toward R4 and told her, "Shut the fuck up you bitch". The report indicated R1 "smacked" her in the mouth four times. The licensee failed to investigate the incident and submit a MAARC report. During an interview on December 12, 2022, at 12:13 p.m., AD-B and RN-I acknowledged that MAARC reports should have been completed and incidents should have been investigated. The licensee's, Reporting of Maltreatment of Vulnerable Adults, policy dated January 25, 2019, indicated a MAARC report would be completed immediately after a vulnerable adult was maltreated. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		