Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259191600M
Compliance #: HL259199164C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:
Centennial Villa
500 Park Street East
Annandale, Mn. 55302
Wright County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Not Substantiated

Nature of Investigation:
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 alleged perpetrator (AP) neglected the resident when the AP failed to follow the resident's plan of care resulting in a fall with injury. Additionally, the AP neglected to follow facility policy and procedure which delayed the resident receiving care after the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the fall, the AP followed the resident's plan of care as directed. Even though the AP did not have the unit phone on their person according to facility policy, the AP used a personal cell phone to request emergency assistance for the resident. The AP's actions did not delay emergency care for the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, the resident, and a family member. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation,

facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff provide direct cares and interact with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included diabetes, long term use of anticoagulants (blood thinners), and repeated falls. The resident's service plan included as needed assistance with incontinence, toileting, positioning, dressing, transferring and ambulation. The resident's assessment indicated the resident had memory deficits, dizziness upon standing, impulsiveness, and ambulated with a two-wheeled walker.

The resident's incident report indicated during a night shift the AP assisted the resident to the bathroom for incontinence cares. The resident attempted to remove her nightgown and fell while the AP was out of the bathroom getting the resident a fresh nightgown. The AP contacted the nurse, and the resident was transported to a local emergency room for an evaluation.

The resident's hospital records indicated the resident had an unwitnessed fall over her walker during the overnight hours and was transferred from a local emergency room to a trauma level hospital due to facial fractures and the resident's use of blood thinners (used to prevent blood clots). The resident had contusions (bruising) to the face, abrasions (cuts) to the forehead, non-operative bilateral nasal bone fractures, raccoon eyes (eyes very swollen), left thigh hematoma (blood pooled under the skin), and sutures to the resident's nose. The resident returned to the facility three days later.

The internal investigation report indicated the resident had fallen in the bathroom when unattended. Following the fall, the AP called for staff assistance and 911. The report included an interview of the resident by a licensed staff and the resident stated she was in the bathroom, was going to put pajamas on and fell. The AP stated she walked the resident into the bathroom and had a nightgown change prepared, however, the resident wanted a different nightgown and the AP, at the resident's request, went to retrieve options for the resident to change into. When the AP left the bathroom, the resident attempted to remove the nightgown she was wearing and fell forward.

During an interview, a licensed staff stated the resident had a history of Impulsiveness, preferred her independence, and would get up on her own. The resident had a call pendant to summon staff and was able to use it. Additionally, the licensed staff stated it was acceptable for unlicensed staff to use a personal cell phone to summon 911 if they did not have a facility phone or walkie-talkie on their person.

During an interview, the AP stated she was aware of the resident's needs and assisted the resident to the bathroom using the resident's walker. The AP stated the resident's nightgown was wet and the resident requested a change in nightgowns. When the AP left the bathroom, the resident when attempting to remove her soiled clothes, fell. The AP stated she called for staff assistance and emergency services to transport the resident to a hospital for an evaluation.

The AP stated she failed to carry a walkie-talkie with her according to facility policy, however she had her personnel cell phone she used to communicate with emergency services.

During an interview, a family member stated the resident had a history of falls at the facility. After the resident's hospitalization, the resident's provider in consultation with the resident and family decided to stop taking blood thinning medications due to the resident's frequent falls.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reviewed the pattern of falls in the memory care unit, investigated the incident and sent the resident to the hospital.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA	500 PARK STREET EAST ANNANDALE, MN 55302

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL259191600M/HL259199164C #HL259193545M/ HL259193863C On July 16, 2024, 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 123 residents receiving services under the assisted living with dementia license. The following correction order is issued for # HL259193545M/ HL259193863C, tag identification 2360 .	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators' 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 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02360	Continued From page 1 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: The facility failed to ensure two of two resident(s) reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred. An individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment reports for details.	02360	No plan of correction is required for this tag.	