



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286867104M
Compliance #: HL286863426C

Date Concluded: August 7, 2023

Name, Address, and County of Licensee

Investigated:

Hyatt House
231 Washington Street
Holdingford, MN 56340
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Jana Wegener, 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 facility abused a resident when they restrained the resident by locking him in his room for extended periods of time. In addition, the facility failed to ensure a clean safe environment when the resident was crawling around in cat feces and urine on the floors.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. The resident was observed with unrestrained access to the facility. No cat feces, or urine was observed on the floors of the facility. When interviewed facility staff and family stated the resident was not restrained in his room.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of resident records including assessment, care plan, progress notes, after visit summaries, staff communication, provider

communication, documentation of services provided, and facility documentation of weekly carpet cleaning. Also, the investigator observed the resident's room and facility environment.

The resident resided in an assisted living facility with diagnoses including developmental delay with nonverbal communication and legal blindness. The resident's assessment indicated he was cognitively impaired due to developmental delays and had poor safety awareness.

The resident's care plan indicated the resident crawled on the floor and generally did not ambulate. The plan indicated the facility provided 15-minute checks, and one to one staffing to ensure safety. The plan indicated the facility would keep hallways clear and free of clutter and provided a clean safe environment for the resident by deep cleaning the carpeted floors in his room, hallways, and common areas weekly.

The resident record indicated the facility had orders for isolation of the resident due to a contagious methicillin resistant staphylococcus aureus (MRSA) infection in his urine. The resident record indicated they received physician orders to implement isolation precautions and isolate the resident for 7-10 days to prevent the potential spread of illness to other residents in the facility.

The next day a faxed communication to the provider indicated due to developmental delays and cognitive impairment the resident was not compliant with being isolated in his room and continuously opened the door and left his room. The record indicated the provider gave orders to discontinue the isolation precautions three days after they were implemented, and the facility discontinued isolation of the resident.

A facility task list indicated the carpets were deep cleaned and shampooed weekly.

When interviewed facility staff stated the resident was not restrained or locked in his room. Staff stated they used a motion sensor that chimed in his doorway to alert them when the resident exited his room so they could be one to one with the resident. Staff stated the carpeting had stains, but the carpets were deep cleaned and shampooed weekly.

The resident was observed in his room in the facility with the door open. The facility carpet had stains, however, no cats, cat odor, cat feces, or cat urine was noted.

The resident's family member indicated she had not observed the resident restrained in his room.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
- (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
- (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
- (4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.
- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No, not interviewable.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: N/A

Action taken by facility:

No action required.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2023
NAME OF PROVIDER OR SUPPLIER HYATT HOUSE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 231 WASHINGTON STREET HOLDINGFORD, MN 56340		
(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 On July 25, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL286863426C/#HL286867104M. No correction orders are issued	0 000	<p>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 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE