DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304381140M **Date Concluded:** April 24, 2023
Compliance #: HL304381781C

Name, Address, and County of Licensee Investigated:
Cedars of Austin Care
700 1st Dr NW
Austin, MN 55912
Mower County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Inconclusive

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):
Allegation #1: The facility neglected the resident when the resident fell and broke his hip.

Allegation #2: The facility financially exploited the resident when scheduled narcotic pain medication was replaced with over-the-counter medication.

Investigative Findings and Conclusion:

Allegation #1: The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and was hospitalized, the facility assessed and sought further medical care appropriately.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's records, the facility's policies and procedures, incident reports, and the resident's medical

record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living dementia care unit. The resident's diagnoses included Alzheimer's disease (type of dementia), history of falls, and joint pain. The resident's service plan included the resident required the assistance of one staff with dressing, grooming, bathing, toileting, and medication management. The resident ambulated with the use of a walker and required staff assistance with transfers. The resident's assessment indicated he was alert to person, but disoriented and forgetful due to dementia.

The facility's incident report indicated the resident called out for help, so unlicensed caregivers responded, found on the floor in his room and contacted the nurse. The nurse assessed the resident and had him transferred the emergency room for evaluation.

The resident's emergency room discharge records indicated ankle and foot x-rays completed and was sent back to the facility the same day with instructions for rest, ice, elevation, and over-the-counter pain medication.

Three days later, the resident's progress indicated the resident was lean onto his left side when sitting and not bearing weight on his right hip. The same note indicated the facility sent the resident back to the emergency room with additional x-rays confirming right hip fracture and underwent surgery to repair the fracture. The resident returned to the facility seven days later.

During interviews, multiple unlicensed caregivers stated the care sheet directed them to check the resident visually every hour. The same caregivers stated they made rounds more frequently to ensure resident was safe due to his history of frequent falls and self-transfers. They also stated the resident di not the call pendant light due to impaired cognition but would yell for help instead.

During an interview, nurse #1 stated the resident had unwitnessed falls and nursing would be contacted to assess for injury. The nurse stated after one of the falls she sent the resident to the emergency department only for the hospital to send the resident back to the facility the same day with a diagnosis of a foot injury. The same nurse stated two or three days later noted she noticed the resident was in pain and not putting weight on the hip, so she requested further x-rays which showed a hip fracture.

During an interview, nurse #2 stated documentation showed resident was at substantial risk for falls and interventions were in place from the date of admission and continued to be updated as needed. The nurse stated after diagnosed with the hip fracture and surgery to repair the resident continued to self-transfer causing the same hip to dislocate.

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

Allegation #2

The Minnesota Department of Health determined neglect was inconclusive. Although drug diversion did occur, the investigation did not identify a specific person as the alleged perpetrator.

During a routine audit of narcotic medications, which are controlled medications, the facility identified the possibility some narcotic pills had been replaced with similar-looking over-the-counter medications, so the facility conducted an internal investigation and contacted local law enforcement.

The facility investigation included a review of the medications and its packaging, security camera footage, and interviews with caregivers who had access to the narcotic pills. The facility investigation did not identify a specific alleged perpetrator. As part of the facility's plan to reduce the risk of recurrence, the medication carts were moved to an area which is monitored with security cameras. As part of the investigation, the families of residents who had medication diverted and paid for a replacement of the medication.

During the Minnesota Department of Health investigation, the investigator conducted an onsite visit and made observations medication carts on each secured unit. The investigator observed the medication carts placed in view of security cameras along with narcotic counts completed with shift changes, and the pills themselves double-locked.

During an interview, nurse #1 stated a caregiver reported a possible drug diversion it was noticed a narcotic medication did not appear to look correct and immediately notified the nurse. The narcotic blister pack was found to have the foil scored, replaced with a similar appearing medication that was not a narcotic, and then foil was sealed with clear tape. The nursing department checked all the narcotic medications and discovered other instances of the same diversion.

The facility's records indicated it conducted retraining for medication administration to include a check of the back of the blister pack before punching the medication.

The Minnesota Department of Health determined financial exploitation was inconclusive.

"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

(a) "Neglect" means neglect by a caregiver or self-neglect.

(b) "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.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Financial Exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: No, attempted but not successful
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility identified and continued to update interventions regarding the resident falls and provide immediate medical attention for possible injuries. Additionally, the facility provided training and education regarding drug diversion.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: ______ B. WING ______	C 03/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	**700 1ST DRIVE NW AUSTIN, MN 55912**

(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: #HL304381140M/HL304381781C On March 6, 2023 the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 121 residents living Assisted Living with Dementia Care license with 36 of these residents living in secured memory care units. . 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 #HL304381140M/HL304381781C , tag	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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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0 000	Continued From page 1 identification 2070.	0 000		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one or more staff were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs in the four secured memory care (MC) units. This had the potential to affect all 36 residents residing in the MC units. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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: The licensee failed to ensure one or more staff were always physically present during all shifts in	02070		

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02070	Continued From page 2 each of the four separate secured MC units as required by Minnesota Rule 144G.81, subdivision 4. On March 6, 2023, the licensee held an Assisted Living with Dementia Care License with a bed capacity of 130, census was 121, with 36 of those residents residing on one of the four secured MC units. The physical layout of the facility consisted of the assisted living apartments (Millpond) and four secured memory care floors (Landmark). The licensee's uniform disclosure of assisted living services & amenities (UDALSA) dated May 20, 2022, indicated unlicensed direct care staff typically scheduled for the entire facility included ten staff on the day shift (6:45 a.m. to 3 p.m.), nine staff on the evening shift (2:45 p.m. to 11 p.m.), and four staff (10:45 p.m. to 7 a.m.) on the overnight shift. On March 6, 2023, review of a facility Service Plan indicated the licensee's contingency plan for essential services stated if the provider is unable to provide essential services per the Service Plan, staff would contact resident's listed contact person to determine if they would be able to assist providing those services. If the contact person for the resident(s) is not able, then the provider would work to make arrangements through another provider. A review of licensee's staff schedule from February 1, 2023, through March 10, 2023, indicated 15 out of 38 days reviewed where memory care unit (MC5) overnight schedules did not have a specific staff member assigned but listed a float. This same period indicated 1 out of 38 days where a staff was not scheduled on MC4 unit and 3 out of the 38 days where a staff was	02070		

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02070	Continued From page 3 scheduled only to 1 a.m. leaving a MC unit to use a float to cover for the remainder of those shifts. During an interview on March 14, 2023, at 2:23 p.m., unlicensed personnel (ULP)-E stated one to two staff are usually scheduled on each MC floor depending on the acuity of cares. ULP-E stated overnight staffing would be short at times with MC5 listed as a float which left MC5 floor unattended. ULP-E further stated there are times when each MC unit had one staff scheduled and the staff from one floor would go assist on another floor, leaving that floor unattended. During an interview on March 20, 2023, at 10:05 a.m., registered nurse (RN)-F stated each of the memory care floors is scheduled for one to two staff. RN-F stated if a floor has only one staff scheduled a staff member from another floor would leave their floor unattended to help in another MC floor. During an interview on March 22, 2023, at 9:00 a.m., RN-A stated MC units have been left unattended briefly when required to assist another floor and during a shortage of staffing, the staff on MC5 would float to other floors, leaving MC5 without a staff physically present in MC5. RN-A stated a staff person would go to MC5 to make sure rounds and cares are completed. RN-A stated this was the licensee's contingency plan during an emergency or when short of staff such as call-ins and MC units have been left unattended briefly when required to assist another floor. The licensee-provided policy titled "Staffing" (Document number 03.019.13) last revised on September 1, 2022, indicated under Current Staffing Levels, page two of three staffing levels	02070		

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02070	Continued From page 4 are outlined in the policy are optimal, with the understanding there may be last minute call-ins and staff emergencies where replacement staff cannot be found and there may be an absence of up to one staff per shift in each area. This same document indicated a contingency plan in the event of staffing issues MC unit would have one staff during the morning shift, one staff in the afternoon and one staff each on MC2, MC3, and MC4 with MC 5 having listed as float. The same document indicated it had been reviewed on January 26, 2023. TIME PERIOD FOR CORRECTION: Two (2) days	02070		