

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306879986M
Compliance #: HL306878191C

Date Concluded: June 17, 2024

Name, Address, and County of Licensee

Investigated:

Benedictine Senior Living
625 Central Avenue
Osseo, MN 55369
Hennepin County

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

Evaluator's Name:

Lisa Coil, RN, BSN, Special Investigator

Finding: Substantiated, facility responsibility

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 neglected the resident when staff did not provide supervision and monitoring for the resident. The resident eloped and was found on the ground outside of the facility.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility documented the resident had cognitive changes (changes in knowledge of observation, thinking, problem solving, and/or memory) and wandering in the facility two months prior to the incident but did not put a safety plan in place to prevent or address the increased risk of elopement.

The investigator conducted interviews with facility staff members, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, facility internal investigation, facility incident reports, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, diabetes, and kidney disease. The resident's service plan included stand by assistance with walking while using a walker, and independent with personal cares. The resident's assessment indicated the resident was easily understood, needed occasional reminders/cues, and was easily confused. The service plan indicated the facility was to provide checks on the resident per housing agreement daily, which was indicated under the stability/falls category. The item further indicated housing checks or "I am OK checks" were included in care coordination and to please check marketing before scheduling more than one time a day.

An incident report indicated the resident was missing from his apartment in the middle of the night and was found on the ground outside in his pajamas and bathrobe. The incident report indicated the resident received a bruise to the right side of his face from the fall.

The facility investigation indicated the residents' wife said the resident slept through dinner. The report further indicated a family member said the resident was probably leaving to get something to eat from the gas station.

On the date of the incident the progress notes indicated a caregiver went to give medication to the residents' wife in the middle of the night and found the resident missing from their shared apartment. The note indicated the building was searched and the resident was found outside one of the facility doors on the ground.

Approximately two months prior to this event, the resident's assessment, under the heading of orientation, indicated the resident reported getting up during odd hours and wandering in the facility. The same document indicated the resident needed extra time to redirect to his room. The same document, under the heading of wandering behavior, indicated caregivers should report any wandering behavior or wandering pattern.

Approximately three weeks prior to this event, the resident's assessment, under the heading of orientation, again indicated the resident reported getting up during odd hours and wandering in the facility. The same document indicated he needed extra time to redirect him to his room. The same document, under the heading of wandering behavior, indicated caregivers should report any wandering behavior or wandering pattern.

While the facility identified a concern with wandering on two separate occasions, the facility did not put any specific services nor safety checks in place to address these concerns.

Following the incident, the resident's progress notes indicated two-hour safety checks were put in place. The note indicated the nurse would meet with family and hospice to discuss steps to ensure the residents safety. Another progress note later the same day, indicated the resident was moved to the memory care unit.

Also following this incident, the Medication Administration Record indicated the resident was to be checked on every two hours to see if he was in his room. The instructions indicated to call nursing right away if the resident was not in his room.

During an interview, unlicensed caregiver #1 stated towards the end of her shift, on the evening of the incident, she found the resident sitting in a chair near the medication cart. Unlicensed caregiver #1 stated this was unusual and the resident had never done that before. Unlicensed caregiver #1 stated she asked the resident if she could help him, the resident said he wanted to go home and asked which way home was. Unlicensed caregiver #1 assumed the resident meant home to his apartment, so she assisted him to his apartment and offered to help the resident to bed; however, he wanted stay up and watch television. Unlicensed caregiver #1 stated she left the resident with his wife watching television. Unlicensed caregiver #1 stated she reported the incident to the oncoming staff, unlicensed caregiver #2. Unlicensed caregiver #1 further stated she was still in the building doing her charting when unlicensed caregiver #2 called and said the resident was not in his apartment. Unlicensed caregiver #1 stated both caregivers started looking for the resident in the halls before checking outside. Unlicensed caregiver #1 stated unlicensed caregiver #2 called and said she found the resident lying on the cement patio outside. Unlicensed caregiver #1 went to the area and the two of them called the nurse. Unlicensed caregiver #1 stated the resident was able to move his extremities, he was able to walk inside, and they took him up to his apartment by wheelchair. Unlicensed caregiver #1 state the resident was not on safety checks because he had never done anything like this before.

During an interview unlicensed caregiver #2 stated the same details of the incident as unlicensed caregiver #1. In addition, unlicensed caregiver #2 stated the nurse had instructed her to check the residents' vital signs one more time that night and to check on him either every hour or every two hours throughout the rest of the shift. Unlicensed caregiver #2 stated she usually works night shifts on a different floor but when she does work on the residents' floor, the resident had always been in bed sleeping. Unlicensed caregiver #2 was not aware of the resident wandering during the times she had worked on the residents' floor.

During an interview, the resident's family member stated prior to this incident the resident's spouse told her the resident had gotten up early in the morning, got dressed, and went down to the dining room several times. The family member stated her mom would wake up, go look for her dad, and find him in the dining room waiting to eat, her mom would take him back to the room because it was too early to eat. The family member stated the resident had been wandering prior to this incident and recalls having discussion with the nurse supervisor regarding his wandering. The family member stated she was unsure of interventions were put in place to prevent elopements from occurring.

During an interview, the nurse supervisor stated the resident had minor confusion and needed minor redirection and simple reminders. The nurse supervisor stated the resident probably went out to take a walk and when he was out, he had a fall. The nurse supervisor stated safety

checks were implemented that night and the resident was moved to the memory care unit the next day. The nurse supervisor stated every assisted living resident was checked on in the morning and if anyone had increased confusion more safety checks could be added to their services. The nurse supervisor stated the resident had one safety check in the morning and received medications two times a day prior to the incident.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: No, he was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility investigated the incident, implemented two-hour checks on the resident throughout the rest of the night, and moved the resident to the memory care unit the following day.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Osseo City Attorney

Osseo Police Department

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30687 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/29/2024 |
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|--|--|
| NAME OF PROVIDER OR SUPPLIER BENEDICTINE SENIOR LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 625 CENTRAL AVENUE OSSEO, MN 55369 |
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| (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 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL306878191C / #HL306879986M</p> <p>On May 29, 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 54 residents receiving services under the provider ' s Assisted Living with Dementia Care license.</p> <p>The following correction order is issued/orders are issued for #HL306879986M, tag identification 2360.</p> | 0 000 | | |
| 02360 | <p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> | 02360 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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|--------------------|---|---------------|---|--------------------|
| 02360 | <p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incident which occurred at the facility. Please refer to the public maltreatment report for details.</p> | 02360 | No plan of correction is required for this tag. See maltreatment report for details. | |