Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HG516006M
Compliance #: HG516005C

Date Concluded: February 1, 2021

Name, Address, and County of Licensee Investigated:
Prairie's Edge
152 Cougar Drive
Mankato, MN 56001
Blue Earth County

Facility Type: Intermediate Care Facility (ICF)

Investigator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, 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.

Allegation:
It is alleged that the alleged perpetrator (AP) physically and emotionally abused the client when the AP scolded the client while she stood over the client, grabbed the client's arms and prevented the client from moving while in his motorized chair.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment. The AP engaged in treatment of the client that a reasonable person would consider humiliating, harassing, or threatening, and caused distress to the client, when the AP blocked the client from exiting the area, grabbed the client's upper arms, and raised her voice while close to the client's face.

The investigation included interviews with administrative and unlicensed facility staff. The investigation included a review of policies and procedures. Employee personnel files were reviewed for training records and backgrounds. Several client medical records were reviewed, including the client's record.

The client had a history of quadriplegia, cerebral palsy and intellectual disability. Review of the client's record indicated the client required assistance from staff for activities of daily living that included personal care, meals, laundry, housekeeping, medication administration and transportation. The client used a motorized wheelchair for mobility. The client had limited verbal communication ability.

Review of the facility incident investigation documents indicated the client was assisted by staff person #1 during his morning medication program when the client became distracted with another concern. The AP, who was also assisting in the client's care, tried to redirect the client and told him to focus on the medication activity. The client, who was in his motorized wheelchair, tried to leave the room. The document indicated the AP stood in front of the client with her legs on either side of him, grabbed the client's arms, got in close and yelled at him to do what he was asked, and turned off the power to the client's chair. The client began to cry and hit himself in the back of the head, which continued for three to five minutes until the AP backed off and turned the power to the chair back on. The client took the medication box and left the room. Staff member #1 stated the client started to cough and appeared shaken up, but was able to complete the medications. The client and staff person #1 stated that the AP turned off the power to the chair. The AP denied turning off the power to the client's chair but admitted she straddled the client's chair, grabbed the client's upper arms and got close to his face and yelled in attempt to get him to listen.

During the maltreatment interview, staff member #1 stated the AP verbally chastised the client, got in front of him while he was in his wheelchair and grabbed his arms. The AP turned the wheelchair power off and moved the joystick out of the client's reach so he could not turn it back on. The incident escalated to the point where the client cried and hit his head, which was a behavior the client experienced when he was stressed out.

The facility director was interviewed and stated the client's service plan directed staff to back off and give the client some time when he has these types of behaviors.

The client was interviewed for the maltreatment investigation but was not able to verbalize details of the incident.

The AP declined an interview with the maltreatment investigator.

In conclusion, abuse was substantiated. The AP blocked the client was leaving the area, contrary to the client's care plan, and then grabbed the client's arms and yelled at the client.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP declined the interview.

Action taken by facility:
The facility conducted an internal investigation. The facility interviewed the client, other clients, staff and the AP. The AP was suspended during the investigation and no longer is employed by the facility.

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.

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 Mental Health and Developmental Disabilities
Blue Earth County Attorney
Mankato City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G516	A. BUILDING _____ B. WING _____	C 06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIES EDGE	152 COUGAR DRIVE MANKATO, MN 56001

(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) COMPLETION DATE
W 000	INITIAL COMMENTS On 6/29/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your was in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaint was found to be substantiated with no deficiency cited due to actions implemented prior to survey. #HG516005C.	W 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.