Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20579009M
Compliance #: HL20579010C

Date Concluded: November 12, 2021

Name, Address, and County of Licensee Investigated:
Prairie Senior Cottages of Willmar
1705 19th Ave SW
Willmar, MN
Kandiyohi County

Facility Type: Home Care Provider

Investigator's Name: Erin Johnson-Crosby, RN, Special Investigator

Finding: Substantiated, facility 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(s):
It is alleged: The facility neglected the client when they failed to supervise the client with a known history of elopement. The client eloped (left the facility unsupervised), fell, and broke his hip.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to supervise the client with a history of elopement. Additionally, the facility failed to train staff on how to properly secure the visiting room door.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also reviewed the client's record and employee files.

The client's diagnoses included dementia and psychosis. The client required cueing for activities of daily living (ADLs) and the client was independent with transfers and ambulation.

The client's vulnerability assessment indicated the client resided in a secured locked facility, had a history of elopement, and required 15-minute checks. The client wandered within the building and into the fenced in courtyard. The staff interventions included documentation of 15-minute checks and check alarms and locked exterior doors.

The client's incident reports indicated the client had attempted to or had eloped on six occasions prior to this incident. The incident report on the day of the elopement indicated the emergency room (ER) notified facility staff their client was in the ER.

The facility's internal investigation indicated emergency medical services (EMS) notified the facility at approximately 9:16 p.m. that EMS found the client and transported the client to the hospital. The same document indicated facility staff reported the last time they saw the client was approximately 6:00 p.m. The facility determined the visiting room door with a code lock was disabled and the exterior door of the visiting room was unlocked. The facility also determined facility staff did not complete required safety checks.

The client's safety monitoring sheet indicated facility staff did not complete safety checks after 6:00 p.m. on the day of the elopement. The safety monitoring sheets for the past 20 days prior to elopement indicated many hours every day staff did not check on the client per the service plan.

The client's hospital records indicated the client admitted to the hospital with a hip fracture, which required surgical repair. The report indicated a bystander found the client outside and the client had fallen. The bystander called 911 and EMS transported the client to the ER.

When interviewed, multiple unlicensed personnel (ULPs) reported the last time they saw the client was approximately two and a half to three hours before receiving a call from the ER. The ULPs said checking doors and alarms was everyone's responsibility. The ULP's also said the visiting room door and exterior doors should be locked after each visit.

When interviewed, the registered nurse (RN) said she was responsible to ensure facility staff completed 15-minute checks per the client's service plan. The RN said she tried to check the safety monitoring sheets every two weeks but may have forgot about it. The RN said she watched video surveillance and saw the client walking to his room after supper on the day of the elopement. The RN said the visiting room door was not visible by the camera which was located right next to the client's room.

When interviewed, the housing director (HD) said she and the RN were responsible to ensure completion of 15-minute checks for the client. The HD said she was not aware the visiting room door with a lock code could disabled by unlocking the deadbolt. The HD said she did not train the staff about the deadbolt because she was unaware the door lock code could become ineffective if the deadbolt was unlocked.

In conclusion 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.

Vulnerable Adult interviewed: No, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Provided staff training and education regarding safety checks, doors and alarms.

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

Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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 Long-Term Care
County Attorney for Kandiyohi County
City Attorney Willmar, MN
Appropriate law enforcement agencies Willmar, MN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20579	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SR COTTAGES WILLMAR	1701-1705 19TH AVENUE SW WILLMAR, MN 56201

(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 The Minnesota Department of Health conducted a maltreatment investigation, in accordance with Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minnesota Statute § 626.557. The Minnesota Department of Health issued a correction order pursuant to the investigation. INITIAL COMMENTS: On October 7, 2021, the Minnesota Department of Health conducted a maltreatment investigation of complaint #HL20579009M. At the time of the investigation, there were #14 clients receiving services under the comprehensive license. The following correction order is issued for #HL20579009M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag. " The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by. " Following the investigators ' 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/RULES.	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of 14 client (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On November 12, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction required for tag 0325. Please see Public Maltreatment Report (sent separately) for details.	