Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21399034M
Compliance #: HL21399035C

Date Concluded: April 17, 2020

Name, Address, and County of Licensee Investigated:
The Prairie Lodge at Earle Brown
6001 Earl Brown Drive
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Yolanda Dawson, 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 alleged perpetrators neglected the client when proper procedure was not used to transfer the client with a mechanical lift and the client suffered a head injury.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility did not have a mechanical lift manual available to staff and did not provide mechanical lift instructions specific to the client. This contributed to the alleged perpetrators (AP) failing to correctly position the sling under the client before the client was lifted from the wheelchair, causing the client to tip backward, slide partway out of the sling and hit her head on the floor. The client required medical attention and received several staples to the back of her head.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigator observed staff utilize the mechanical lift. Internal investigation notes and photos were reviewed. Review of personnel files indicated staff received training on the use of the mechanical lift.

The client lived in the memory care housing unit and received comprehensive care from the home care provider for all cares and activities of daily living. The client's diagnoses included dementia, hypertension, and peripheral neuropathy. The client was also receiving hospice care services for late onset Alzheimer's decease.

One afternoon, AP #1 and AP #2 were transferring the client from her wheelchair to the bed. As the client was being lifted, AP #2 took the client by her feet and lifted them up to clear the bottom of the lift. The client tipped backward, slid partway out of the sling and hit her head on the floor. The client's legs were still in the sling and AP #1 lifted her head and they continued to move the client to the bed.

During an interview, an administrator stated staff were trained on the facilities EZ Way mechanical lift. The administrator stated hospice provided the mechanical lift for this client that was a Lumex brand and staff were not individually trained on the Lumex mechanical lift. At the time of the incident, the client's service plan did not contain mechanical lift instructions that included the sling size and which loop to use when transferring the client. The administrator stated that these instructions were added to the service plan after the incident.

During an observation, a staff member stated she had not seen a manual or instructions of any kind, but had received mechanical lift training, and would ask the nurse if she had any questions.

Internal investigation notes indicated AP #1 showed administrators how the incident occurred. AP #1 stated the client was sitting in her wheelchair with the sling under her. The mechanical lift was placed across the client from the side of the wheelchair. AP #1 stated AP #2 was controlling the lift, but then stated she was steering the lift with one arm and spotting the client's head with the other. AP #1 stated AP #2 was at the client's feet. AP #1 stated when they started to move the client to the bed, the client fell backward and she could not grab her fast enough and her head hit the floor. The administrator stated that positioning the chair from the side of the wheelchair was not a common practice and not consistent with how they were trained.

Internal investigation notes indicated that during an interview, AP #1 stated to administrators that the sling was not all the way up in the back and agreed this was not standard procedure.

Internal investigation notes indicated that during an interview, AP #2 stated to administrators that the sling was not up all the way on the client's back, which is what caused the accident.

In conclusion, neglect was substantiated. The facility failed to ensure staff were trained on the model of lift being used for the client, or that instructions on the use of the lift were available. This contributed to the client being incorrectly transferred, resulting in injury.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but unable to reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
An internal investigation was conducted. The alleged perpetrators are no longer employed by the facility. Staff were reeducated on the proper use of the mechanical lift. A new mechanical stand/lift policy was devised. Management audited all harnesses and slings to ensure each resident had their own correct size harness. Service plans were revised to include mechanical lift instructions specific to the client.

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
Hennepin County Attorney
Brooklyn Center Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21399	A. BUILDING: _____ B. WING _____	C 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BROWN	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order pursuant to a survey. 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: On March 6, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL21399035C/#HL21399034M. At the time of the survey, there were #68 clients receiving services under the comprehensive license. The following correction order is issued for #HL21399035C/#HL21399034M, 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 for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal	0 325		

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0 325	Continued From page 1 abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable 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 one clients reviewed C1 was free from maltreatment. C1 was neglected. Findings include: On April 16, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that 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 (PoC) required. Please refer to the maltreatment public report for details.	